Tennessee

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 08/29/2017 12.20.51 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State DUNS Number

Number 878890425

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name Tennessee Department of Mental Health and Substance Abuse Services

Organizational Unit Division of Planning, Research and Forensics

Mailing Address 5th Floor Andrew Jackson Building 500 Deaderick Avenue

City Nashville

Zip Code 37243

II. Contact Person for the Grantee of the Block Grant

First Name Marie

Last Name Williams

Agency Name Tennessee Department of Mental Health and Substance Abuse Services

Mailing Address 6th Floor Andrew Jackson Building 500 Deaderick Street

City Nashville

Zip Code 37243

Telephone 615-253-3049

Fax

Email Address Marie.Williams@tn.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 8/29/2017 12:20:04 PM

Revision Date

V. Contact Person Responsible for Application Submission

First Name Avis

Last Name Easley

Telephone 615-253-6397

Fax

Email Address avis.easley@tn.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
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Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
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Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

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Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Marie Williams, LCSW

Signature of CEO or Designee[1]: _____

Title: Commissioner

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

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Fiscal Year 2018

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Name of Chief Executive Officer (CEO) or Designee: Marie Williams, LCSW

Signature of CEO or Designee[1]: Marie Williams

Title: Commissioner

Date Signed: 07/17/2017

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

BILL HASLAM
GOVERNOR
STATE OF TENNESSEE

January 4, 2017

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Dear Ms. Simmons:

As the Governor of the State of Tennessee, for the duration of my tenure, I delegate authority to the current Commissioner of the Department of Mental Health and Substance Abuse Services, Marie Williams, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG) and Mental Health Block Grant (MHBG).

Contact information for Commissioner Williams is as follows:

Marie Williams
Commissioner
Tennessee Department of Mental Health and Substance Abuse Services
6th Floor, Andrew Jackson Building
500 Deaderick Street
Nashville, TN 37243
615-532-6500 (Office)
615-532-6514 (Fax)
marie.williams@tn.gov

Thank you for your assistance.

Sincerely,

Bill Haslam

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:
[B] a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action
[A] a. bid/offer/application
b. initial award
c. post-award

3. Report Type:
[A] a. initial filing
b. material change

For Material Change Only:

Year _____ Quarter _____

date of last report

4. Name and Address of Reporting Entity:

[X] Prime [ ] Subawardee

Tier _____, if known: _____

Tennessee Department of Mental Health and Substance Abuse Services
500 Deaderick Street, 6th Floor
Andrew Jackson Building
Nashville, TN 37243

Congressional District, *if known:* _____

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known:* _____

6. Federal Department/Agency:
Health and Human Services / SAMHSA

7. Federal Program Name/Description:
Community Mental Health Services Block Grant

CFDA Number, *if applicable:* _____

8. Federal Action Number, if known:

9. Award Amount, if known:
$

10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*

None

b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*

None

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: Marie Williams SW

Print Name: Marie Williams, LCSW

Title: Commissioner

Telephone No.: 615-532-3049 **Date:** 7/27/17

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Standard Form - LLL (Rev. 7-97)

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: NONE

Page of

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name

Marie Williams

Title

Commissioner

Organization

Tennessee Department of Mental Health and Substance Abuse Services

Signature:

Date:

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Section 2: Planning Steps

Step 1: Strengths and Organizational Capacity of the service system to address the specific populations

Table of Contents

Strengths and Organizational Capacity of the Service System

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) serves as the state's mental health and substance use disorders and opioid treatment authority. TDMHSAS is responsible for system planning, setting policy and quality standards, system monitoring and evaluation, disseminating public information and advocacy for persons of all ages who live with mental illness, serious emotional disturbance, and/or substance use disorders.

Planning and Policy Council System, Research, and Data

TDMHSAS administers seven Regional Planning and Policy Councils (Council[s]) from which regional mental health and substance abuse needs and information are funneled to the Statewide Council and to TDMHSAS. Needs assessment priorities and recommendations from the Statewide Planning and Policy Council, combined with requirements associated with federal Mental Health and Substance Abuse Block Grant funding, inform the development of the Department's Three-Year Plan. Title 33, Chapter 2, Part 2 of the Tennessee Code Annotated requires the TDMHSAS to develop a Three-Year Plan (Plan) based on input from the TDMHSAS Planning and Policy Council. The Plan must be revised at least annually based on an assessment of the public need for mental health and substance use disorders services.

Data is provided to the Regional Councils to assist members with identifying and prioritizing needs. Following the sharing of data, a needs assessment is conducted annually by the TDMHSAS Regional Councils to assist TDMHSAS with planning for resource allocation. Prioritized needs are shared with TDMHSAS staff to inform the development of strategies for the Three-Year Plan and report progress annually.

The needs assessment process creates a data-informed method for Regional Councils to influence the design of the mental health and substance use service delivery system by identifying each region's needs and targeting limited state resources to more effectively and efficiently meet identified needs. This information is used to communicate and integrate results into a strategic planning and action process that ensures assessment information is used in meaningful ways. Dashboards and other data sets are used to determine needs.

In addition to the needs assessment, the Councils also review and provide input on the Block Grant plans and funding, the annual budget for TDMHSAS, legislative proposals for review of the Commissioner and possible consideration by the Governor, and other Departmental reports and initiatives.

The Council system is large, robust, active, and fully-integrated with individuals from both the substance abuse and mental health communities with a consistently successful method of integration. It acts as an independent body and great care is taken by the Department to avoid influencing the deliberations of, and recommendations made by, the Councils. The Regional Council system serves a secondary purpose that, although not part of the legal requirement, is beneficial to the service delivery system in Tennessee: the Councils allow all participants to become acquainted with each other and with services, events, and other aspects of the service delivery system.

Organization of TDMHSAS

Office of the Commissioner is made up of the Commissioner, Deputy Commissioner, and Executive Administrative staff. This Office oversees and leads the Department in its vision to be the nation's most innovative and proactive state behavioral health authority for Tennesseans dealing with mental health and substance abuse problems. The Office is responsible for system planning; setting policy and quality standards; system monitoring and evaluation; disseminating public information; and advocating for people of all ages who have mental health issues, serious emotional disturbances, and/or substance abuse disorders. Annually the office assesses the public's needs for mental health and substance abuse services and supports. This function is carried out in consultation and collaboration with current or former service recipients; their families, guardians, or conservators; advocates; provider agencies; and other affected people and organizations.

Division of Administrative and Regulatory Services (DARS) oversees monitoring, information technology, general services, procurement, major maintenance, capital outlay projects, oversight for the administration function of the Regional Mental Health Institutes, licensing of all Tennessee agencies providing mental health, substance abuse, and personal support services, and investigating complaints of abuse, neglect or fraud against licensed organizations.

Division of Mental Health Services (DMHS) administers and supports a diverse array of services and supports for individuals of all ages living with mental illness, co-occurring disorders, and/or serious emotional disturbances. DMHS creates and oversees community-based programs and community support services for adults and children, housing, crisis services, suicide prevention and peer-to-peer recovery services.

Division of Substance Abuse Services (DSAS) is responsible for planning, developing, administering, and evaluating a statewide system of prevention, treatment, recovery support services for the general public, persons at risk for substance abuse, persons abusing substances, and recovery courts.

Division of Hospital Services (DHS) provides oversight of operation of the four Regional Mental Health Institutes (RMHIs) for administrative, quality management, program services, and nursing services.

Division of General Counsel (DGC) includes the Offices of Legal Services, Investigations, Contracts, and Legislation and Rules providing Department-wide services in support of the Governor and Commissioner's mission and goals. The General Counsel oversees those offices and serves as the chief legal advisor to the Commissioner and senior leadership.

Division of Clinical Leadership (DCL) promotes high quality services through consultations, clinical oversight, education, the development and revision of clinical policies and best practice guidelines, and the advancement of research reviews.

Division of Planning, Research, and Forensics (DPRF) provides planning, policy decision support and program evaluation, and forensic and juvenile court services administration.

Office of Communications (OC) develops internal and external communication including the drafting, production, and distribution of news releases and statements to the media, publication of quarterly Department newsletters, and managing the Department's website.

Office of Fiscal Services oversees general accounting functions including accounts receivable and payable and interactions with state and federal funding sources.

Office of Human Resources (OHR) works to ensure the Department has a workforce capable of fulfilling its mission and objectives through policy advice and technical assistance to managers and staff at the Central Office and Regional Mental Health Institutes on matters such as Americans with Disability Act, Equal Employment Opportunity, employee relations, benefits, recruiting, training, performance evaluations, and personnel actions.

Organization of the Service Delivery System at the State Level

Goals central to TDMHSAS's operations are used to develop strategic programming in both the mental health and substance abuse delivery systems. The Department's planning goals include the following Customer Focus Goals:

1. Efficient and effective management of the Regional Mental Health Institutes (RMHIs)
2. Maintain and improve community mental health and substance abuse services
3. Provide effective education and prevention services
4. Lead in partnership with state agencies and community partners to prevent and treat prescription drug abuse epidemic in Tennessee

Each Division of TDMHSAS (listed on page 4) develops strategies for programming and/or direct services based on each of the above-referenced goals and also reports bi-annually on the outcomes of the programs (new and existing) or the plans in progress based on these main goals. The Division of Mental Health Services (DMHS) is responsible for implementing programming that utilizes Mental Health Block Grant dollars. The Division of Substance Abuse Services (DSAS) is responsible for the programming that utilizes the Substance Abuse Block Grant dollars.

TennCare, the state's Medicaid agency, operates under the purview of the Tennessee Department of Finance and Administration. TDMHSAS acts in collaboration with, and consultation for, TennCare and provides services and programs that fill the gaps for those services for SMI/SED/SUD and others diagnosed with mental health concerns not covered by TennCare. For example, TennCare and TDMHSAS act in concert to provide statewide Crisis Services for both TennCare beneficiaries and citizens who are not eligible for TennCare or covered by insurance. Crisis Services could not function at the necessary level of care and competence without the collaborative effort of both organizations. The preponderance of direct behavioral health care is funded through Medicaid (TennCare) benefits for the population served by TennCare and TDMHSAS. TDMHSAS provides funding for ancillary services not covered by TennCare, Medicare or another insurance plan.

One direct service program is operated through TDMHSAS DMHS: the First Episode Psychosis Initiative. The funding for the treatment piece of the program is a collaborative effort between TennCare and TDMHSAS. Planning, development, training, outreach, public information and implementation are funded through Block Grant dollars. Some direct service is also funded by the Mental Health Block Grant in the event that a patient fits the parameters of the program but is unable to pay for services or there are co-pays that the patient is unable to pay. Otherwise, the provider bills the patient's insurance company for services rendered.

Different ages and populations are served by different benefit plans via TennCare, the Behavioral Health Safety Net of Tennessee (BHSNTN) and different ancillary service programming. Funding includes grants and federal and state funding funneled from and through TDMHSAS. TennCare provides a range of services to eligible children and adults covered by Medicaid benefit plans. TennCare's Plan array utilizes an eligibility algorithm that pairs individuals with benefit plans ranging from shared cost plans (with and without Medicare and other benefit sources) to total coverage through TennCare at no cost to the patient.

Other State Departments also provide behavioral health treatment components embedded in services already provided. Examples include the Department of Corrections which provides behavioral health services to inmates when needed and the Department of Children's Services which provides behavioral health services through TennCare to children involved in the child welfare system.

Organization of the Service System at the Local Level

In Tennessee, there are a full range of facilities licensed by the TDMHSAS for mental health and substance abuse delivery purposes.

At the time of this application there are licensed agencies as follows (not the total list of licenses--see https://mh.tn.gov/Licensure/Inquiry.aspx?RPT=TDMHSAS%20License%20Inquiry to view the total list and categories at the local level):

Crisis Stabilization Units (CSUs)	10 Licensees with 9 sites
Mental Health Supportive Living	140 Licensees with 229 sites
Outpatient Facilities	148 Licensees with 446 sites
Mental Health (only) Hospitals (includes state hospitals)	15 Licensees with 15 sites
Residential Rehabilitation Treatment SA	41 Licensees with 62 sites
Residential Treatment SA Children and Youth	13 Licensees with 20 sites
Residential Detox Center SA	30 Licensees with 43 sites

For the above categories and licenses, and other services offered locally through the service delivery system, TDMHSAS establishes contracts for services according to funding and program with each organization. TennCare contracts with four statewide Managed Care Organizations (MCOs) which then subcontract for services within the three grand regions of the state (East, Middle, and West). Some medical hospitals which are licensed through the Department of Health also offer psychiatric care as part of the service milieu. Medical hospitals offering psychiatric beds have such beds included in the need calculations for the State (for psychiatric beds) as new or altered facilities are reviewed and approved, but are not licensed by TDMHSAS. Overall, the review, monitoring, and licensing of behavioral health providers are shared tasks (among Tennessee Departments) depending on the service offered and the context in which it is offered.

Licensed and contracted agencies are required to comply with state and federal law related to serving persons who may need an interpreter (for deaf and hard of hearing and for individuals for whom English may not be the native language). While there are no specific laws or regulations guarding the rights of gender, minorities, or sexual orientation concerns in the state, each contracted provider receiving federal Block Grant dollars must provide culturally sensitive services that meet the needs of all specific populations required by federal law.

Services and corresponding funding are distributed to the seven Planning and Policy Council Regions based on a number of factors including the following:

- Annual needs assessment conducted by the Regional Planning and Policy Councils.
- Anecdotal information available to the public in general (i.e. need for Veteran's services in areas around a military base, need for homelessness services in urban areas where it is known that many homeless persons exist, etc.).
- Data gathered that illustrates that certain needs for services exist in certain regions (i.e. increased levels of opiate addiction or overdose shown in certain areas of the state, increased levels of suicide shown to exist in certain areas of the state, increased need for children's services shown to exist in urban areas, etc.).
- The discretion of the Commissioner to place services.
- The discretion of the Governor to place services.
- The appropriations approved by the State Legislature.
- Recommendations from the Statewide Planning and Policy Council.

Statutory Criterion for Mental Health Block Grant

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

The Department supports a number of recovery services that are intended to increase the recovery capital of people with mental health and co-occurring disorders. The Wellness & Employment Office provides Individual Placement and Support (IPS) Supported Employment services which are recovery services to help people reintegrate into their communities through competitive, steady employment. The Peer Wellness Initiative prioritizes physical health as a tool to improve mental health recovery.

The Behavioral Health Safety Net of TN is a state funded program that provides vital mental health services to uninsured Tennesseans who are eligible. The services provided through the BHSN of TN are intended to reduce initial hospitalizations and the recidivism rate. The services consist of: assessment, evaluation, diagnostic, therapeutic intervention, case management, peer support services, psychosocial rehabilitation services, psychiatric medication management, labs related to medication management, and pharmacy assistance and coordination.

Crisis response services are the single point of entry to a continuum of behavioral health services and supports needed by someone experiencing a behavioral health crisis. Tennessee Crisis Services incorporate a continuum of crisis services, including mobile crisis, crisis stabilization, respite and walk-in center services. The philosophy is based on determining the most appropriate intervention needed to successfully alleviate the crisis in the least restrictive environment available to meet the needs of the individual. Additionally, the TDMHSAS and Tennessee Hospital Association (THA) brought together a public/private collaboration among community partners and formed a work group to review Tennessee's current psychiatric care delivery system. These efforts include a key emphasis on providing treatment immediately at the point of entry into the health care system. The work group has developed a recommended set of Psychiatric Treatment Protocols for Emergency Departments (EDs) and encourages all EDs across the state to implement these psychiatric protocols in their hospitals.

Through the First Episode Psychosis Initiative, three OnTrackTN programs provide individualized services to youth and young adults experiencing a first episode of psychosis. Youth and young adults involved in these programs experience a large reduction in number and length of hospital stays. System of Care Across Tennessee provides high-intensity wraparound services to families of children with SED with the intent of reducing out-of-home placements, including hospitalizations.

The Department routinely monitors readmission rates for 7 and 30 day readmissions to the state and three contracted private hospitals. Each time an individual is readmitted within 7 or 30 days, a special review of the person's prior discharge plan is conducted to identify treatment failures and potential opportunities for improvement in planning the individual's plan of care.

Tennessee is fortunate to have 24/7 access to crisis services across the state, making several diversionary alternatives available such as medically monitored crisis detoxification, crisis stabilization units, walk-in centers and respite services. The crisis system serves as the gate keeper to inpatient care.

Tennessee has also adopted the Zero Suicide Initiative aimed at improving identification of risk, safety planning, follow-up care and routine monitoring of individuals at risk of dying by suicide. Though this initiative increases identification of individuals at risk of dying by suicide which potentially increases reliance on psychiatric inpatient care, it has also improved coordination of care among multiple providers and has improved engagement with outpatient services.

Tennessee rules and statues are designed to protect individuals from unnecessary involuntary hospitalization by requiring evaluation by two qualified mental health professionals. The first evaluation must be done by a professional unaffiliated with the inpatient service and the second is completed by the admitting physician. Individuals who do not meet commitment criteria for involuntary hospitalization are offered less restrictive alternatives to involuntary care and treatment.

The Tennessee Move Initiative (TMI) began in FY2017 with the primary purpose of successfully transitioning identified individuals from long-term units to community based housing by providing ongoing, intensive, and individualized support to individuals, families, and community providers. TMI agencies provide recovery-focused, intensive, and customized care coordination services to identify individuals in long-term units (on average 90 + days and individuals who have had multiple admissions over a 90-120 day period) within state hospitals. The purpose of the initiative is to transition the individuals to the least restrictive and most integrated setting appropriate based on individual need. Each partner agency has developed and implemented recovery-oriented programming to ensure individual, family, and housing provider supports while connecting and coordinating with natural and formal supports within the individual's home community. The goals of TMI include: decreasing prolonged hospitalizations and repeated readmissions that impose negative implications on an individuals' quality of life, including their path to recovery; delivering recovery-focused, intensive, and customized care coordination services which support identified individuals in the least restrictive and most integrated setting appropriate to individual need; ensuring a continuity of care which leads to sustained hope, personal empowerment, respect, social connectedness, and self-responsibility relative to the individuals served; providing services centered on the individual, sensitive to the family, culturally and linguistically competent, and founded in community resources.

Criterion 2: Mental Health System Data Epidemiology

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
Adults with SMI	360,751	180,838
Children with SED	99,075	86,290

A) The target population is all adults with SMI and children with SED regardless of income. (B) Tennessee uses NRI estimates of the prevalence of adults with SMI and children, ages 9-17, with SED. (C) Tennessee uses the URS tables to estimate the incidence of SMI and SED, because the URS tables contain data provided by the State Medicaid Authority, in addition to individuals served by the Department of Mental Health and Substance Abuse Services.

Criterion 3: Children's Services

TDMHSAS oversees a variety of children and youth programs, including areas such as advocacy, school-based liaisons, transition age youth, System of Care (SOC), anti-stigma, violence and bullying prevention, respite, faith-based mental health, prevention and early intervention. These programs are financed through multiple funding sources, state and federal discretionary grants, such as the Mental Health Block Grant (MHBG) and Substance Abuse Prevention Treatment Block Grant (SAPTBG).

The Council on Children's Mental Health (CCMH) works to design a comprehensive plan for a statewide SOC for children and families that is family-driven, youth-guided, community-based, and culturally and linguistically competent. This Council is co-chaired by the Commissioner of the Tennessee Department on Mental Health and Substance Abuse Services (TDMHSAS) and the Executive Director of the Tennessee Commission on Children and Youth (TCCY) and membership represents a focused, diverse and integrated community of all Tennessee child-serving agencies, community providers, advocates, families, children and youth.

CCMH is a collaborative effort focused on growth and development with emphasis over the past year on cutting-edge topics in children's mental health, including statewide trauma initiatives, trauma-informed care, education initiatives, and, most recently an emphasis on CCMH's future direction to further support the comprehensive plan for a statewide SOC for children and families in Tennessee. CCMH participants provide the state with a centralized community of knowledgeable members participating in ad hoc workgroups, providing technical assistance activities, and supporting conferences and trainings conducted by TDMHSAS' Office of Children and Youth Mental Health.

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Homeless populations within the State of Tennessee who are living with mental illness, substance abuse, or co-occurring disorders have a variety of programs available to provide permanent supportive housing and other financial services to facilitate independence in the community and increased access to behavioral health care. The programs designed to assist homeless populations include Community Supportive Housing, Projects for Assistance in the Transition for Homelessness (PATH), Inpatient Targeted Transitional Support, Community Targeted Transitional Support, Intensive Long-term Support, Emerging Adult Services, and Children and Youth Homeless Outreach Project (CYHOP). In rural areas, the PATH program provides outreach services to individuals experiencing episodes of homelessness and

the Community Targeted Transitional Support program provides rental, utility, dental, and vision financial supplements to assist individuals at-risk of entering homelessness.

The Older Adult Program provides care management to individuals over 50 who would not otherwise be eligible for services. Services may include assessment, outreach, linkage, in home therapy and other supportive resources. In addition, community mental health education is provided to promote awareness regarding geriatric issues. These services are provided to improve quality of life and to develop skills to enable the older adult to continue to live independently in the community.

IPS Supported Employment is a model of employment with research indicating that it is a successful model for rural communities. Currently, there are three Individual Placement and Support (IPS) Providers in rural communities. There are also five IPS Provider specifically targeting the homeless population. The Peer Wellness programming is provided by four providers in rural areas.

The Department provides several programs targeted to rural populations: Project B.A.S.I.C. (Better Attitudes and Skills in Children), a school-based mental health early intervention and prevention program, in 35 Tennessee counties, including 23 of Tennessee's most rural counties; School Based Behavioral Health Liaisons in ten Tennessee counties, including four of Tennessee's most rural counties; System of Care Across Tennessee in four counties, including two of Tennessee's most rural counties; and the First Episode Psychosis Initiative in nine Tennessee Counties, including seven of west Tennessee's most rural counties. Other programs providing outreach to rural Tennessee counties include Violence & Bullying Prevention (a school-based bullying prevention program) and Family Support & Advocacy. Carey Counseling Center, Inc. provides targeted services to youth and young adults in rural Northwest Tennessee. Through Healthy Transitions and FEPI, Carey Counseling was able to enhance its telehealth ability and increase its capacity to serve youth and young adults in a rural area.

The crisis continuum of service is available to all Tennesseans. Crisis assessments are community based and are available statewide in both rural and urban areas. Crisis services are available to all age groups and to individuals including those that reside in the state's jails and/or are homeless.

The Behavioral Health Safety Net of TN is available to eligible uninsured adult Tennesseans who live in rural areas of the state and/or homeless.

Criterion 5: Management Systems

TDMHSAS is responsible for system planning; setting policy and quality standards; licensing personal support services agencies, mental health and substance use services and facilities; system monitoring and evaluation; and disseminating public information and advocacy for persons of all ages who live with serious mental illness (SMI), serious emotional disturbance (SED), substance use disorder (SUD), and/or co-occurring disorder (COD). Through the operation of four (4) fully accredited Regional Mental Health Institutes (RMHIs), TDMHSAS also provides inpatient psychiatric services for adults, including acute, sub-acute, and forensic. TDMHSAS is comprised of the following department Offices and Divisions: Office of the Commissioner; Division of Administrative and Regulatory Services; Division of Mental Health

Services; Division of Substance Abuse Services; Division of Hospital Services; Division of General Counsel; Division of Clinical Leadership; Division of Planning, Research, and Forensics; Office of Communications; Office of Fiscal Services; and Office of Human Resources. Through the department Offices and Divisions, TDMHSAS provides a quality spectrum of services across the lifespan. Collaborative efforts across a variety of service systems, both public and private, including but not limited to mental health, substance use, criminal justice, veterans, and child/family organizations. Such efforts create a cross-systems approach and promote the most effective outcome for care.

The Division of Mental Health Services (DMHS) is responsible for implementing programming that utilizes Mental Health Block Grant dollars. The Division of Substance Abuse Services (DSAS) is responsible for the programming that utilizes the Substance Abuse Block Grant dollars.

TennCare, the state's Medicaid agency, operates under the purview of the Tennessee Department of Finance and Administration. TDMHSAS acts in collaboration with, and consultation for, TennCare and provides services and programs that fill the gaps for those services for SMI/SED/SUD and others diagnosed with mental health concerns not covered by TennCare.

Conclusion

Tennessee's Department of Mental Health and Substance Abuse Services is charged with:

- operating the State's Regional Mental Health Institutes (state hospitals);
- developing a service array for Substance Abuse and Mental Health services that seeks to comply with state and federal law;
- meeting the needs of the citizens; and
- serving as the opiate treatment authority for the state.

TDMHSAS operates Block Grant funded, state funded, and discretionary grant funded programs that meet the needs of the SMI/SED population. Cultural competence and linguistic sensitivity is considered and embedded into the programming requirements. Communities and populations that may have limited access to mental health care are considered and have needs addressed including rural populations, all sexual orientations, and individuals with a need for an innovative approach to care. TDMHSAS also serves in a consultative capacity to the state's Medicaid agency (TennCare) and assists other Departments with implementing effective policies and programming regarding related services. TDMHSAS licenses and monitors the service delivery system, and participates in the process of the delivery system's development and enhancement. The program milieu either offered by or administered by TDMHSAS is consistent with best practices and supported by the latest research.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state?s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state?s unique data system (including community-level data), as well as SAMHSA?s data sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorderprevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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[1] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

Step 2: Identify Unmet Service Needs and Critical Gaps within the Current System

TDMHSAS has made a concerted effort to align the Mental Health Block Grant and Three-Year Plan to ensure that strategic planning is consistent regardless of funding source. The Three-Year Plan is required by Title 33 to inform the public of the Department's goals, objectives, and strategies for the next three years. The Plan includes prevention, early intervention, treatment service, and supports for people living with mental illness, serious emotional disturbance, and/or substance use disorders. An annual assessment of need for services and supports is used to develop the Plan. The Plan is updated annually to reflect milestones in the achievement of Department goals and objectives.

The Governor has provided broad areas of focus to each State Department known as Customer-Focused Government goals (CFG). The TDMHSAS Commissioner has developed goals and objectives for the Department that not only address the Governor's focus, but also address the needs of the citizens and take into consideration the guidelines and requirements inherent in diverse funding resources including the federal Block Grant program.

The Commissioner's goals for TDMHSAS as they pertain to the Governor's plans for Tennessee are as follows:

1. Effective and efficient management of Regional Mental Health Institute (RMHI) facilities;
2. Strengthen and improve community mental health and substance abuse services;
3. Provide effective substance abuse prevention and treatment services; and
4. Lead in partnership with State agencies and community partners to prevent and treat the prescription drug abuse epidemic in Tennessee.

In aligning all Plans, and in order to ensure that the needs of SED/SMI individuals are met throughout the state, common threads appear along the following priority areas for the Mental Health Block Grant:

1. Maintain and improve community mental health services.
2. Promote early intervention by educating Tennesseans and working to improve their understanding of mental health and substance abuse issues.

Program staff has developed programming that fits into one of the goals. The milieu of services contracted through TDMHSAS is such that some programming could be considered outside of one of the priority areas associated with the Department's Three-Year Plan. All programming is designed to meet a need, however specific, for the citizens of Tennessee.

The Block Grants provide critical resources for the state to be able to achieve these goals. Mental Health Block Grant (MHBG) funds provide essential dollars needed for strengthening community mental health services, expanding and improving mental health services to children, decreasing health disparities and encouraging consumer recovery, resiliency and personal achievement.

To determine the unmet service needs and critical gaps within the current service system, TDMHSAS conducts a data-driven needs assessment based on the compilation of behavioral health data from multiple data sources into data books comparing Tennessee to the United States and compiling county level behavioral health data.

Needs Assessment Process

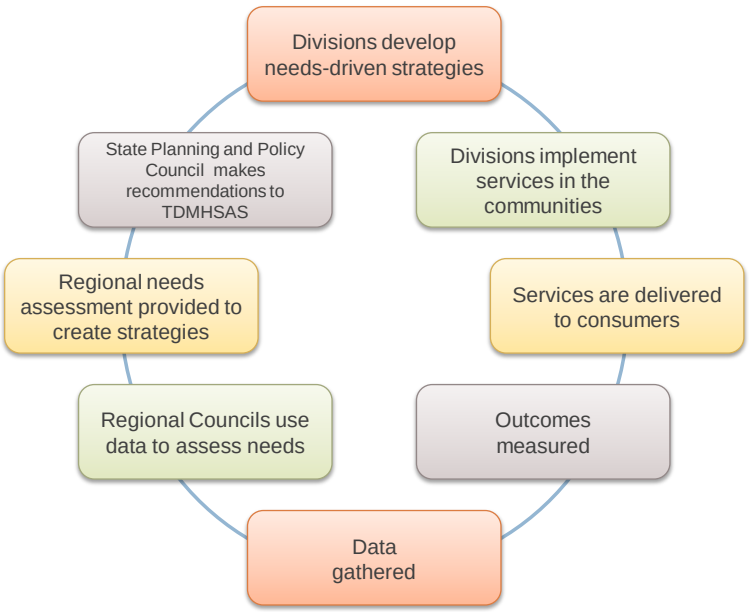
Service needs are identified through an annual needs assessment process with input from TDMHSAS Statewide Planning and Policy Council (Council), the Regional Council system, and TDMHSAS staff. Regional needs are identified, reviewed, and prioritized by the Planning and Budget Committee of the Council as recommendations for inclusion into the TDMHSAS Three-Year Plan. This process allows for a broad grassroots forum to advise the Department on the desirable array of prevention, early intervention, treatment, and rehabilitative services and supports for consumers and their families. Additionally, this

process allows for citizen participation in the development of the TDMHSAS annual budget improvement request.

The TDMHSAS needs assessment process involves state level collaboration involving the TDMHSAS Research Team, the TDMHSAS Statewide Planning and Policy Council, and other TDMHSAS staff. TDMHSAS also administers seven Regional Planning and Policy Councils across the seven geographically defined state treatment planning areas. The seven Regional Councils are comprised of consumers and their families, advocates, adults and older adults, providers, and other stakeholders and organizations. The Councils advise the TDMHSAS Statewide Planning and Policy Council on the development of the state Three-Year Plan and provide guidance to the Department on policy, budgeting, and evaluation from the regional perspective. This engagement process embodies TDMHSAS' mission and commitment to establishing a quality, comprehensive prevention, early intervention, treatment, and rehabilitation system based on the needs and preferences of individual consumers and their families.

The goals of the needs assessment model are to identify unmet needs and critical gaps, and to allocate limited resources more efficiently. The model is also designed to help Regional Councils prioritize local needs, direct state level planning and resource allocation efforts, and assure compliance with federal block grant funding requirements. The needs assessment model outlines eight steps as part of a cyclical process that begins with implementing needs-driven services in communities, proceeds to collecting and analyzing indicators of prevalence, service use, quality, and outcomes, and results in formulating recommendations for service strategies that reflect emergent regional needs and preferences. These recommendations are further shaped by outside considerations, such as federal and state policy initiatives and priorities, legal requirements, and funding constraints. The TDMHSAS needs assessment model is described in detail in Exhibit 1.2.

Exhibit 1.2
TDMHSAS Needs Assessment Model



- **Divisions implement services in the communities.** TDMHSAS funds needs-driven community mental health services.
- **Services are delivered to consumers.** Providers deliver a comprehensive array of prevention, intervention, treatment, and recovery support services.
- **Outcomes measured.** Providers measure consumer outcomes resulting from the service experiences.
- **Data gathered.** TDMHSAS uses extant data sources and provider, consumer, and stakeholder surveys to compile indicators of mental health prevalence, system capacity, service utilization, service quality, and unmet need. Information is used to identify trends, patterns and other useful information that can inform future service delivery planning and resource allocation.
- **Regional councils use data to assess needs.** Regional councils identify local strengths and weaknesses and prioritize needs using previously collected data.
- **Regional needs assessment provided to create strategies.** Integrating results into the strategic planning process to ensure that findings from the assessment process are used in meaningful ways and those changes to service systems are driven by local input.

Data Sources

To inform the needs assessment process, TDMHSAS developed a number of data books comparing state-specific and national data, as well as providing Regional Planning and Policy Councils with regional and county-level data. Data books are posted on the TDMHSAS website. Information about the TDMHSAS needs assessment process and the data used to determine regional and state needs is posted on the department's website at http://tn.gov/behavioral-health. TDMHSAS utilized various data sources to inform the regional and county data books including, but not limited to:

- Behavioral Health Safety Net of Tennessee (BHSNTN)
- Behavioral Risk Factor Surveillance System (BRFSS) and the Youth BRFSS with the Centers for Disease Control and Prevention
- Kids Count website (http://datacenter.kidscount.org)
- National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)
- SAMHSA: National Survey on Drug Use and Health (NSDUH)
- SAMHSA Uniform Reporting System tables
- SAMHSA: Treatment Episode Data Set
- Tennessee Department of Health
- Tennessee Health Care Financing Administration: TennCare (state Medicaid program)
- Tennessee Outcome Measurement System (TOMS)
- Youth Risk Behavior Survey
- U.S. Census

In addition to the data books which are provided to the Statewide and Regional Councils, the Office of Research provided a Needs Assessment Data Report to provide program specific data to councils about needs identified in the statewide needs assessment. The Report is posted on the department's website at http://tn.gov/behavioral-health.

The 2017 Need Assessment Summary includes needs and critical gaps identified by the Regional Councils, Statewide Children and Adult Committee, and the Consumer Advisory Board (CAB). The multiple needs identified by regions include: Crisis Stabilization Units (CSUs) for children and youth; increase appropriate and affordable supportive housing; reliable and affordable transportation to and from treatment; and increase certified peer recovery services and specialists.

Currently, there is no funding available for CSUs for children and youth. TDMHSAS, TennCare, and Manage Care Organizations (MCOs) have worked in collaboration and explored the option of expanding services to include Children and Youth (C & Y) CSUs. This included engaging providers, stakeholders, and community partners across the state in an effort to assess children and youth service needs. TDMHSAS, TennCare, MCO's, and state agencies will continue to work collaboratively to address the treatment needs of children and youth through TennCare initiatives aimed at expanding/enhancing intensive in-home treatment services (e.g., Home-based Treatment/Intensive Care Coordination), where we expect to produce more robust outcomes for children/youth and their families. Transportation services are provided by MCOs contracted through TennCare and private companies.

The Summary is posted on the on the department's website at http://tn.gov/behavioral-health/article/needs-assessment.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Maintain and improve services

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Maintain and improve community mental health services.

Objective:

Provide support for programs striving to maintain and improve community mental health services by way of (1) ensuring access to treatment services for the uninsured; (2) maintaining high quality and effective crisis services; (3-5) continuing the creation, development, and maintenance of safe, affordable housing opportunities from high-intensity 24-hour facilities to independent living; (6-7) improving early screening, assessment, treatment and recovery support services for children with SED and individuals experiencing ESMI; (8) maintaining care management services for older adults; (9) improving rates of employment through evidence based programs; and (10) improving overall wellness and recovery with support of peers.

Strategies to attain the objective:

Program strategies supporting objective: Behavioral Health Safety Net; crisis services continuum network; Creating Homes Initiative, Targeted Transitional Services, Community Supportive Housing, Intensive Long-term Support, Emerging Adults, and Supportive Living programs; early intervention services from System of Care Across Tennessee, Healthy Transitions, School Based Liaisons, Project B.A.S.I.C. (Better Attitudes and Skills In Children), Regional Intervention Program; First Episode Psychosis Initiative; Older Adults care management; Supported Employment initiative; and peer support, including peer wellness coaching.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Numbers of uninsured adults in Tennessee who receive treatment, medication, case management and/or psychosocial rehabilitation services from the Behavioral Health Safety Net of TN.

Baseline Measurement: In state FY2017, there were 29,000 served by the Behavioral Health Safety Net of TN.

First-year target/outcome measurement: Serve as many uninsured individuals as are eligible and apply to the Behavioral Health Safety Net of TN during state FY 2018.

Second-year target/outcome measurement: Serve as many uninsured individuals as are eligible and apply to the Behavioral Health Safety Net of TN during state FY 2019.

Data Source:

Behavioral Health Safety Net of TN (BHSNTN) data as tracked and reported by Behavioral Health Safety Net of TN database.

Description of Data:

Behavioral Health Safety Net provides core, essential, outpatient, mental health services to uninsured Tennesseans who meet program eligibility criteria through a network of 15 participating community mental health centers.

Data issues/caveats that affect outcome measures::

none noted.

Indicator #: 2

Indicator: Number of individuals (adults and children) experiencing a mental health crisis to receive high quality and effective crisis services via the Crisis Services Continuum network of services.

Baseline Measurement:	In state FY2017, there were 200,000 served by the Crisis Services Continuum network of services.
First-year target/outcome measurement:	Maintain or increase the total number served by the Crisis Services Continuum during state FY2018.
Second-year target/outcome measurement:	Maintain or increase the total number served by the Crisis Services Continuum during state FY2019.

Data Source:

The state Crisis Management System will track and report data related to the Crisis Services Continuum network of services.

Description of Data:

Aggregate data for this indicator will be compiled from the Crisis Management System from providers statewide to include the following services: phone calls, mobile crisis, walk in center, crisis respite, crisis stabilization units, and East TN Diversionary Services, as reported by the Division of Mental Health, Office of Crisis Services and Suicide Prevention.

Data issues/caveats that affect outcome measures::

none noted.

Indicator #:	3
Indicator:	Number of new or improved safe, affordable housing or supported living opportunities developed or maintained for people with history of mental illness.
Baseline Measurement:	In state FY2017, there were 800 new or improved housing or supported living opportunities available statewide through the Creating Homes Initiative (CHI).
First-year target/outcome measurement:	Maintain or increase the total number of new or improved housing or supported living opportunities available through CHI during state FY2018.
Second-year target/outcome measurement:	Maintain or increase the total number of new or improved housing or supported living opportunities available through CHI during state FY2019.

Data Source:

Number of new or improved housing or supported living opportunities will be available through Creating Homes Initiative (CHI) as reported by Regional Housing Facilitators to the Office of Housing & Homeless Services.

Description of Data:

Regional Housing Facilitators are located within the 7 mental health planning regions of Tennessee to plan, develop and maintain permanent supportive housing opportunities for people with mental illness or co-occurring disorders through community coalitions and partnerships.

Data issues/caveats that affect outcome measures::

none noted.

Indicator #:	4
Indicator:	Number of individuals (adults) experiencing mental illness that are able to live independently and maintain stable housing through short-term financial support.
Baseline Measurement:	In state FY2017, 2,900 individuals experiencing mental illness received assistance to maintain stable independent housing with short-term financial support.
First-year target/outcome measurement:	Maintain or increase the total number of individuals able to maintain stable housing with short-term financial support during state FY2018.
Second-year target/outcome measurement:	Maintain or increase the total number of individuals able to maintain stable housing with short-term financial support during state FY2019.

Data Source:

Number of individuals receiving short-term financial housing support is reported by Community Targeted Transitional Services (CTTS)

and Inpatient Targeted Transitional Services (ITTS) programs in the SAMHSA Homeless Management Information System and reviewed by the DMHS Office of Housing & Homeless Services.

Description of Data:

CTTS program provides specific, temporary financial assistance allowing consumers to live independently in the community by providing funding for rental deposits, rental assistance, utility deposits, utility payments, eye care, and dental care.
ITTS program assists persons awaiting discharge from RMHIs by providing them temporary financial assistance until their regular SSI or other benefits can be restored, thereby enabling them to move into community settings when clinically ready.

Data issues/caveats that affect outcome measures::

none noted.

Indicator #:	5
Indicator:	Number of individuals (adults) experiencing mental illness that are able to live in the community and maintain long-term supportive housing.
Baseline Measurement:	In state FY2017, 1,300 individuals experiencing mental illness were able to maintain stable long-term supportive housing.
First-year target/outcome measurement:	Maintain or increase the total number of individuals receiving long-term supportive housing during state FY2018.
Second-year target/outcome measurement:	Maintain or increase the total number of individuals receiving long-term supportive housing during state FY2019.

Data Source:

Number of individuals served in housing facilities receiving long-term supportive housing as reported from the Community Supportive Housing, Intensive Long-term Support, Emerging Adults, and Supportive Living programs by the DMHS Office of Housing & Homeless Services.

Description of Data:

Community Supportive Housing supports agencies to provide supported housing for adults diagnosed with mental illness and co-occurring disorders. This program includes housing developed through the Creating Homes Initiative (CHI), a strategic plan to partner with local communities on a grassroots level to create permanent housing options for Tennesseans with mental illness.
Intensive Long-term Support provides intensive long-term, wrap-around support services to allow people to be discharged from the Regional Mental Health Institutes and into supportive living facilities in the community.
Emerging Adults program provides a comprehensive array of supportive housing and habilitation services for youth ages 18 to 25 living with serious emotional disturbances (SED) who have recently graduated out of the State's foster care system and/or adolescent residential recovery for mental illness or co-occurring disorder. As the youth demonstrate their ability to live more independently, they move to a neighboring housing with decreased supervision before transitioning to fully independent living.
Supportive Living group home facilities across the state.

Data issues/caveats that affect outcome measures::

none noted.

Indicator #:	6
Indicator:	Number of children, youth, young adults and their families who receive early screening, assessment, referral, and services for children, youth and young adults diagnosed with, or at risk of developing Severe Mental Illness (SMI), Serious Emotional Disturbance (SED), or Co-Occurring Disorder (COD).
Baseline Measurement:	In state FY2017, 7,900 children, youth, young adults, and their families were served by programs offering access to early screening, assessment, referral, and intervention services.
First-year target/outcome measurement:	Maintain or increase the total number of individuals served through C&Y early intervention and prevention programs during state FY2018.
Second-year target/outcome measurement:	Maintain or increase the total number of individuals served through C&Y early intervention and prevention

Data Source:

Number of individuals served as reported from B.A.S.I.C., School Based Behavioral Health Liaisons, Early Intervention and Prevention Program, Regional Intervention Program, System of Care Across Tennessee and Healthy Transitions programs by the DMHS Office of Children & Youth Mental Health.

Description of Data:

System of Care Across Tennessee (SOCAT) provides wraparound services to children ages 0-21 with a diagnosis of a serious emotional disturbance (SED) who are at-risk of placement in a residential treatment facility, psychiatric residential treatment facility, or in state's custody. Data includes the number of children served.
Healthy Transitions provides support services to youth and young adults ages 16-25 who have or are at risk of having or developing a serious mental health condition or co-occurring disorder, and who reside in one of the following Tennessee counties: Benton, Carroll, Gibson, Hamilton, Henry, Lake, Obion, or Weakley. Data includes number of youth and young adults served.
B.A.S.I.C. provides school-based early intervention and prevention services to children in grades K-3 utilizing the Pyramid Model framework. Data for this indicator will include number of individual students served.
School Based Behavioral Health Liaisons provides school-based mental health services, including the provision of brief therapy, assessment, and psycho-educational groups for children and youth who have or at-risk of developing a SED. Data includes number of youth that participated in psycho-education groups and number of youth seen for assistance including one to one sessions for purpose of assessing and/or referring.
The Early Intervention and Prevention Program provides services to children at-risk of SED or substance abuse and their mothers who are enrolled in the grantee's residential treatment facility and have a substance use disorder and/or history of trauma. Services include child and/or family counseling sessions, parenting classes, and family preservation services. Data includes total number of children and mothers served.
Regional Intervention Program provides parent-implemented and professionally supported positive behavioral support services to families whose children have moderate to severe behavior problems and who are under 6 years of age. Data includes number of target children served.

Data issues/caveats that affect outcome measures::

System of Care Across Tennessee initiative is in its first year of providing services and, therefore, no baseline data was included for FY17.

Indicator #:	7
Indicator:	Number of youth and young adults who have experienced first episode psychosis that receive evidence-based treatment and recovery support services.
Baseline Measurement:	In state FY2017, 70 youth and young adults experiencing first episode psychosis received evidence-based treatment and recovery support services.
First-year target/outcome measurement:	Maintain or increase the total number of youth and young adults receiving treatment and recovery support services during state FY2018.
Second-year target/outcome measurement:	Maintain or increase the total number of youth and young adults receiving treatment and recovery support services during state FY2019.

Data Source:

Number of youth and young adults who have experienced first episode psychosis and received treatment and recovery support services by the First Episode Psychosis Initiative (FEPI) program as reported by the Office of Children and Youth Mental Health.

Description of Data:

First Episode Psychosis Initiative (FEPI) program provides early intervention services for selected youth and young adults fifteen through thirty (15-30) years of age physically present in the Tennessee Counties of Benton, Carroll, Gibson, Henry, Lake, Obion, and Weakley who have experienced first-episode psychosis. This is a comprehensive intervention model for people who have experienced a first episode of psychosis. Treatment is provided by a team of mental health professionals who focus on helping people work toward personal goals and to get their life back on track. The program includes the following components: individual and group psychotherapy, supported employment and education, family education and support, psychopharmacology, and care coordination and management.

Data issues/caveats that affect outcome measures::

none noted.

Indicator #:	8
Indicator:	Number of older adults (age 50+) with mental health needs that receive a variety of care

	management services to support living as independently as possible in the community.
Baseline Measurement:	In state FY2017, 200 older adult individuals experiencing mental illness received care management services.
First-year target/outcome measurement:	Maintain or increase the total number of older adult individuals receiving care management services during state FY2018.
Second-year target/outcome measurement:	Maintain or increase the total number of older adult individuals receiving care management services during state FY2019.

Data Source:

Number of older adults who have received care management services and support by the Older Adults program as reported by the Office of Older Adults.

Description of Data:

Older Adults program provides counseling to seniors in-home or otherwise unable to access services ; care management, clinical social work, and geriatric psychiatry assisting seniors and their families to meet their behavioral health needs; and in-home depression screenings as part of the service array.

Data issues/caveats that affect outcome measures::

none noted.

Indicator #:	9
Indicator:	Percentage rate of employment for individuals (adults) with SMI and/or COD is increased through participation in Individual Placement and Support Supported Employment initiative.
Baseline Measurement:	In state FY2017, 800 individuals were served through the evidence-based Individual Placement and Support Supported Employment initiative.
First-year target/outcome measurement:	Approximately 40% of the individuals served through the evidence-based Individual Placement and Support Supported Employment initiative will be employed in competitive and integrated work for at least one day during state FY2018.
Second-year target/outcome measurement:	Maintain or increase the percentage of the individuals served through the Individual Placement and Support Supported Employment initiative employed in competitive and integrated work for at least one day during state FY2019.

Data Source:

Percentage of total individuals served through Individual Placement and Support Supported Employment initiative who are employed in competitive and integrated work for at least one day as reported by the DMHS Office of Wellness and Employment

Description of Data:

Supported Employment initiative assists individuals with a serious mental illness and/or co-occurring disorders work at competitive and integrated jobs of their choosing, following the Individual and Placement Support (IPS) Supported Employment evidence-based model of supported employment.

Data issues/caveats that affect outcome measures::

none noted.

Indicator #:	10
Indicator:	Number of individuals (adults) with serious mental illness, substance abuse diagnoses, and co-occurring disorders who receive support from self-management workshops or one-on-one peer wellness coaching delivered by Peer Wellness Coaches.
Baseline Measurement:	In state FY2017, 800 individuals participated in self-management workshops or received one-on-one peer wellness coaching
First-year target/outcome measurement:	Maintain or increase the total number of individuals participating in self-management workshops or receiving one-on-one peer wellness coaching during state FY2018.

Second-year target/outcome measurement: Maintain or increase the total number of individuals participating in self-management workshops or receiving one-on-one peer wellness coaching during state FY2019.

Data Source:

Number of individuals served through self-management workshops or one-on-one peer wellness coaching delivered by state-funded Peer Wellness Coaches as reported by the Office of Wellness and Employment.

Description of Data:

Peer Wellness Initiative program is a component of the statewide, peer-led health and wellness initiative, which promotes chronic disease prevention and self-management programming for individuals with mental illness, substance use disorders, and co-occurring disorders. Statewide Peer Wellness Coaches and Trainer provide mental health and co-occurring treatment and recovery services providers with health and wellness training, technical assistance, and ongoing support in implementing health and wellness programming.

Data issues/caveats that affect outcome measures::

none noted.

Indicator #: 11

Indicator: Number of Certified Peer Recovery Specialist supervisors who receive enhanced training in specialized subject matter to support peer-led recovery efforts across the state.

Baseline Measurement: In FY2017, 40 Certified Peer Recovery Specialists receive enhanced supervisor training.

First-year target/outcome measurement: Increase or maintain the total number trained in FY2018.

Second-year target/outcome measurement: Increase or maintain the total number trained in FY2019.

Data Source:

Number of Certified Peer Recovery Specialists who receive enhanced training in a specialized subject as reported by the DMHS Office of Consumer Affairs and Peer Recovery Services (new program from FY16).

Description of Data:

Certified Peer Recovery Specialist program provides State certification for individuals who provide direct peer-to-peer support services to others who have mental illness, substance abuse, or co-occurring disorders.

Data issues/caveats that affect outcome measures::

none noted.

Priority #: 2

Priority Area: Promote early intervention

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Educating Tennesseans and working to improve their understanding of mental health and substance abuse issues and getting people to early intervention services.

Objective:

Provide support for programs promoting early intervention for mental health services by way of (1) supporting provision of suicide warning signs and risk factors training; (2) implementation of zero suicide framework; and (3) promote understanding of mental illness among individuals, families and child and youth serving professionals.

Strategies to attain the objective:

Program strategies supporting objective: suicide training and screening from Mental Health 101, Tennessee Lives Count , School & Communities Youth Screen and Project Tennessee programs; integration of zero suicide framework from TN Suicide Prevention Network; and trainings provided featuring child, youth and young adult mental health topics including Erase the Stigma, System of Care Across Tennessee, Healthy Transitions, First Episode

Psychosis Initiative, Project B.A.S.I.C., Family Support & Advocacy, Violence & Bullying Prevention, and Child Care Consultation programs.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of children and youth receiving suicide prevention and post-vention training and/or screenings to support awareness of suicide warning signs and risk factors.
Baseline Measurement:	In state FY2017, 439,400 individuals (children and youth) participating in suicide prevention and post-vention training and/or screenings.
First-year target/outcome measurement:	Maintain or increase the total number of individuals participating in suicide prevention and post-vention training and/or screenings during state FY2018.
Second-year target/outcome measurement:	Maintain or increase the total number of individuals participating in suicide prevention and post-vention training and/or screenings during state FY2019.

Data Source:

Number of children and youth receiving suicide prevention and post-vention training and/or screening as reported by the Mental Health 101, Tennessee Lives Count (CONNECT), School & Communities Youth Screen Program and Project Tennessee programs to the Office of Crisis Services and Suicide Prevention.

Description of Data:

Mental Health 101 program provides mental health information with a focus on youth suicide prevention and resources to middle and senior high school students statewide.
Tennessee Lives Count (CONNECT) program is a statewide youth early prevention and intervention program to reduce suicides and suicide attempts for youth and young adults ages 10 to 24.
School & Communities Youth Screen Program uses scientifically-based screening tool designed to identify at-risk youth; provide effective interventions to assist with their treatment. TeenScreen is a national mental health and suicide risk-screening program for youth.
Project Tennessee program provides 2-hour educational curriculum for teachers, students and parents about the signs of suicide; provides tools and resources needed to identify at-risk youth.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:	2
Indicator:	Number of agencies across Tennessee to embed the zero suicide framework aimed at reducing suicide attempts and deaths within their organization and improving service linkage.
Baseline Measurement:	In state FY2017, 21 organizations adopted the zero suicide framework within their organization (ex: behavioral health agencies, substance abuse agencies, primary care agencies, emergency services).
First-year target/outcome measurement:	Maintain or increase the total number of organizations to adopt the zero suicide framework within their organization during state FY2018.
Second-year target/outcome measurement:	Maintain or increase the total number of organizations to adopt the zero suicide framework within their organization during state FY2018.

Data Source:

Number of agencies to embed the zero suicide framework within their organization in collaboration with Tennessee Suicide Prevention Network (TSPN) and Office of Crisis Services and Suicide Prevention.

Description of Data:

Tennessee Suicide Prevention Network is a statewide coalition of agencies, advocates and consumers that oversee continuing implementation of suicide prevention strategies in Tennessee to eliminate/reduce the incidence of suicide across the life span, to reduce the stigma of seeking help associated with suicide, and to educate communities throughout Tennessee about suicide prevention and intervention strategies.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:	3
Indicator:	Number of families, children, youth/young adults, and professionals who receive training and education on topics related to social-emotional and behavioral health concerns for young children, children, youth, and young adults
Baseline Measurement:	In FY2017, 9,000 trainings were provided statewide with focus on children and youth mental health.
First-year target/outcome measurement:	Maintain or increase the number of trainings provided statewide with focus on children and youth mental health during FY2018.
Second-year target/outcome measurement:	Maintain or increase the number of trainings provided statewide with focus on children and youth mental health during FY2019.

Data Source:

Total presentations and trainings (all ages) delivered by child, youth and young adult focused prevention and awareness promotion programs including Erase the Stigma, System of Care Across TN, Healthy Transitions, First Episode Psychosis Initiative, Project B.A.S.I.C., Family Support & Advocacy, Violence & Bullying Prevention, and Child Care Consultation programs as reported by the Office of Children and Youth.

Description of Data:

Erase the Stigma is a mental health awareness curriculum, delivered primarily in schools, that promotes understanding of mental illness and reduces stigma through puppets, storytelling and interactive exercises, including the I.C. HOPE duck. Data includes total school presentations and community presentations.
Project B.A.S.I.C. (Better Attitudes and Skills In Children) is a school-based, mental health prevention and early intervention service that focuses on the promotion of mental health in children in the earliest school grades (K – 3rd grade). Data includes total number of student classroom presentations conducted by grade.
Family Support & Advocacy program is a comprehensive family advocacy, outreach, support, and referral service for families of children with SED and professionals who work with these children. Also provides information and training to lay and professional groups; maintains a resource library of books and publications; a webpage that provides mental health resources; provides a quarterly, informative and educational newsletter. Data will include presentations and trainings.
Violence & Bullying Prevention program is a violence prevention and resiliency for youth in grades 4-8; uses the Second Step curriculum, an evidence-based practice that teaches empathy, impulse control, decision-making skills and anger management. Data includes number of group sessions.
Child Care Consultation program provides early childhood mental health training, coaching and consultation (using best practices) to centers and systems that serve young children across the state. In addition, capacity development and awareness building will be provided around the need for early childhood mental health and healthy social emotional development. Data includes total number of trainings provided.
System of Care Across Tennessee (SOCAT) is in the development phase of a statewide Technical Assistance (TA) Center that will provide presentations and trainings throughout the state related to young children, children, youth, and young adults, social emotional, and/or behavioral concerns.
Healthy Transitions programs includes outreach and public awareness as key activities of the grant with the goal of increased community education on the specific needs of youth/young adults, stigma reduction, and increased access to services. Data includes presentations to other mental health and youth-serving system professionals, trainings for youth and young adults, and Mental Health First Aid trainings.
First Episode Psychosis Initiative provides outreach and engagement as key activities with the goal of increased community education on psychosis, stigma reduction, and increased access to services. Data includes presentations to other mental health and youth-serving professionals and trainings for youth and young adults.

Data issues/caveats that affect outcome measures::

None noted.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention		$0	$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention							
b. Mental Health Primary*			$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		$1,601,600	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$35,296,000	$11,878,800	$221,683,200	$1,375,400	$5,983,600
7. Other 24 Hour Care		$4,323,600	$0	$0	$46,666,600	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$9,333,900	$0	$24,046,000	$150,582,600	$483,600	$612,800
9. Administration (Excluding Program and Provider Level)		$762,600	$607,600	$7,155,600	$31,045,800	$0	$2,699,400
10. SubTotal (1,2,3,4,9)	$0	$762,600	$607,600	$7,155,600	$31,045,800	$0	$2,699,400
11. SubTotal (5,6,7,8)	$0	$15,259,100	$35,296,000	$35,924,800	$418,932,400	$1,859,000	$6,596,400
12. Total	$0	$16,021,700	$35,903,600	$43,080,400	$449,978,200	$1,859,000	$9,295,800

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMH or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems	$0			
2. Infrastructure Support	$0			
3. Partnerships, community outreach, and needs assessment	$0			
4. Planning Council Activities (MHBG required, SABG optional)	$68,000			
5. Quality Assurance and Improvement	$0			
6. Research and Evaluation	$0			
7. Training and Education	$480,000			
8. Total	$548,000	$0	$0	$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[33] Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[28] Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39; http://www.cdc.gov/socialdeterminants/Index.html

[29] http://www.samhsa.gov/health-disparities/strategic-initiatives

[30] http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

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[36] Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf

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[43] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[44] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

   The Bureau of TennCare (State Medicaid Authority) recently launched (December 2016) an initiative called “Tennessee Health Link” (THL). The primary objective of THL is to coordinate health care services for TennCare members with the most significant behavioral health needs. THL is built to encourage the integration of physical and behavioral health, as well as mental health recovery, giving every individual a chance to reach his or her full potential for living a rewarding and increasingly independent life in the community. TDMHSAS and the majority of Community Mental Health Centers (CMHCs) within the state are THL providers. TDMHSAS has worked and will continue to work closely with TennCare and the provider network as this comprehensive integration effort is fully implemented.

   Integrated care is promoted through the My Health, My Choice, My Life program. This program is a peer-led health promotion and wellness initiative for Tennesseans who live with mental health and substance use conditions. The holistic health initiative integrates a medical model with recovery and resiliency, resulting in an initiative that focuses on overcoming physical and mental health symptoms through strengths, personal empowerment and resiliency. It is led by peer wellness coaches who have firsthand, lived experience with mental health and substance use disorders and are employed by community mental health providers. My Health, My Choice, My Life provides individuals with self-directed tools, empowering them with the knowledge, skills and resources to improve their overall well-being and resiliency and live healthy and purposeful lives.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

TDMHSAS continues to provide leadership for advancing integrated systems of care for individuals with co-occurring disorders. This is evident through the department's support of the Tennessee Co-Occurring Disorders Collaborative (TNCODC). This multi-agency effort aims to create a common understanding of the impact and treatment of co-occurring disorders in Tennessee communities. The primary goals of TNCODC include (1) to share knowledge about the conditions and available resources, (2) reduce stigma, and (3) accurately direct people to timely and effective prevention, treatment, and support.

The Statewide Peer Wellness Coach and Trainer program supports integrated systems of care. This program provides and coordinates health and wellness, recovery and peer support training, technical assistance, and on-going support to Peer Support Center staff, Community Behavioral Health Center staff and Certified Peer Recovery Specialists, among others. This training and supports assist providers in delivering evidence-based health and wellness programming for people with co-occurring mental and substance use disorders in their communities.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ( ) Yes ( ) No

   and Medicaid? ( ) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

   The SMI/SED focused services covered under Tennessee's Block Grant funding are ancillary and fill gaps by providing services not covered by insurance. There has been no initiative yet developed that will monitor access to all behavioral health services in Tennessee. The TennCare program supports a comprehensive benefit array that is provided through subcontracts between three Managed Care Organizations (MCOs) and providers in all three grand regions of Tennessee.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ( ) Yes ( ) No

6. Do the behavioral health providers screen and refer for:

   a) Prevention and wellness education ( ) Yes ( ) No

   b) Health risks such as

      i) heart disease ( ) Yes ( ) No

      ii) hypertension ( ) Yes ( ) No

      viii) high cholesterol ( ) Yes ( ) No

      ix) diabetes ( ) Yes ( ) No

   c) Recovery supports ( ) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ( ) Yes ( ) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ( ) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

   Tennessee is facing the following issues related to the implementation and enforcement of parity provisions.
   • Increasing awareness of the protections that parity provides.
   • Improving understanding of the requirements of parity and of its protections among key stakeholders, including consumers, providers, employers, insurance issuers, and state regulators.
   • Increasing the transparency of the compliance process and the support, resources, and tools available to ensure that coverage is in compliance with parity, and concurrently improve the monitoring and enforcement process.

10. Does the state have any activities related to this section that you would like to highlight?

    The Division of Mental Health, Office of Wellness and Employment, supports the implementation of five evidence-based health and wellness programs by providing ongoing training and up to date licensing of curriculum for: Chronic Disease Self-Management Program, Diabetes Self-Management Program, Tobacco Free Program, Well Body Program, and Whole Health Action Management Program.

    Please indicate areas of technical assistance needed related to this section

    N/A

Footnotes:

TennCare and the Department of Commerce is involved in the implementation and enforcement of parity protections for mental and

substance use disorder services in Tennessee.

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities[45], Healthy People, 2020[46], National Stakeholder Strategy for Achieving Health Equity[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[48].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[51]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[45] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[46] http://www.healthypeople.gov/2020/default.aspx

[47] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[48] http://www.thinkculturalhealth.hhs.gov

[49] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[50] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[51] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

    a) Race — Yes / No

    b) Ethnicity — Yes / No

    c) Gender — Yes / No

    d) Sexual orientation — Yes / No

    e) Gender identity — Yes / No

    f) Age — Yes / No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? — Yes / No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? — Yes / No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? — Yes / No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? — Yes / No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? — Yes / No

7. Does the state have any activities related to this section that you would like to highlight?

    Please indicate areas of technical assistance needed related to this section

Footnotes:

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (TIPS)[57] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[58] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[52] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[53] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[54] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[55] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[56] http://psychiatryonline.org/

[57] http://store.samhsa.gov

[58] http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ☐ Yes ☐ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

   a) ☐ Leadership support, including investment of human and financial resources.

   b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

   c) ☐ Use of financial and non-financial incentives for providers or consumers.

   d) ☐ Provider involvement in planning value-based purchasing.

   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.

   f) ☐ Quality measures focus on consumer outcomes rather than care processes.

   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (•) Yes ( ) No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? (•) Yes ( ) No

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   TDMHSAS has chosen to implement the OnTrackNY model, which was developed through the Recovery After an Initial Schizophrenia Episode (RAISE) Connection Program. This model utilizes the Coordinated Specialty Care (CSC) evidence-based practice to provide early intervention services for youth and young adults experiencing a first episode of psychosis. Treatment is provided by team a of mental health professionals who focus on helping individuals work toward personal goals and lead full and productive lives. More broadly, the CSC model helps individuals navigate the road to recovery from a first episode of psychosis, including supporting efforts to function well at home, at work or school, and in the community. The CSC program includes the following components: individual and group psychotherapy, supported employment and education, family education and support, psychopharmacology, and care coordination and management.

   TDMHSAS has contracted with three providers to implement a coordinated specialty care (CSC) program for youth and young adults experiencing a first episode of psychosis using the OnTrackNY model. These programs also utilize the Individual Placement and Support (IPS) model for supported employment and education as well as peer support through Certified Peer Recovery Specialists. Carey Counseling Center, Inc. provides services in the rural northwest Tennessee counties of Carroll, Gibson, Henry, Lake, Obion, and Weakley Counties. Mental Health Cooperative provides services in Davidson County. Alliance Healthcare Services provides services in Shelby County.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

   Tennessee has expanded OnTrackTN to two additional sites and coordinated new staff training and ongoing consultation with

OnTrackUSA. The state has begun to develop a statewide First Episode Psychosis Learning Collaborative consisting of the three current OnTrackTN teams as well as other community partners and providers in order to increase awareness and early detection and increase statewide capacity to provide first episode of psychosis (FEP) services. As a part of the FEP Learning Collaborative, the state is planning its second statewide First Episode Psychosis Conference to be held in September 2017.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? ( ) Yes ( ) No

5. Does the state collect data specifically related to ESMI? ( ) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ( ) Yes ( ) No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

TDMHSAS has expanded the OnTrackTN program to two additional sites, both of which have been trained in the OnTrackNY model and participate in ongoing consultation with OnTrackUSA. This model utilizes the Coordinated Specialty Care (CSC) evidence-based practice to provide early intervention services for youth and young adults experiencing a first episode of psychosis. These programs also utilize the Individual Placement and Support (IPS) model for supported employment and education as well as peer support through Certified Peer Recovery Specialists. In addition, all OnTrackTN programs will participate in further training on youth and young adult engagement.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

TDMHSAS will continue to support the current OnTrackTN programs and increase efforts to ensure sustainability of the OnTrackTN programs by investigating alternative reimbursement methods. In FFY18, TDMHSAS will expand its evaluation of the First Episode Psychosis Initiative by implementing fidelity measures. The third First Episode Psychosis Conference will be held in FFY19.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

TDMHSAS collects a quarterly program report from each OnTrackTN program that tracks data on items such as staffing, outreach and engagement activities, team meetings, and numbers served. In addition, TDMHSAS collects semi-annual client-level data pulled from admission, follow-up, and discharge forms that capture items such as education and employment status, hospitalizations, global functioning, medication side effects, services received. TDMHSAS develops semi-annual reports based on this data. The state is in the process of analyzing additional client-level data as well as developing a fidelity scale to determine the extent to which the OnTrackTN programs are implementing the OnTrackNY model.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Children and Adults:
o Must be between fifteen through thirty (15-30) years of age;
o Live in Davidson, Shelby, Benton, Carroll, Gibson, Henry, Lake, Obion, or Weakley Counties; and
o Currently have, or anytime in the past twenty four (24) months had, a diagnosable psychosis spectrum condition including schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, or other serious mental illness that warrants psychosis interventions such as depression with psychosis, bipolar disorder with psychosis, or others that meet diagnostic criteria in the Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5), or more current edition.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? (j) Yes (j) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Tennessee has 45 peer-run Peer Support Centers throughout the state where Certified Peer Recovery Specialists work with consumers on self-management of their health, including making health care decisions and communicating with their providers. Certified Peer Recovery Specialists provide self-management classes in the chronic disease self-management system, diabetes self-management system, well body, tobacco free, and the wellness recovery action plan (WRAP). In addition, the statewide consumer organization, Tennessee Mental Health Consumers' Association, provides peer support throughout the state that engages consumers in managing their health.

The state has a Certified Family Support Specialist certification program in which parents can become certified to provide peer-to-peer support services to parents of a child with a serious emotional disturbance (SED). The State also has a Certified Peer Recovery Specialist program (CPRS) and is working on adding a CPRS Transition Age designation for youth and young adults living with an SED or serious mental illness (SMI). Within the Office of Children & Youth Mental Health, the System of Care Across Tennessee lab sites employ Family Support Specialists, and both the On Track TN (FEPI) and Healthy Transitions lab sites employ Peer Recovery Specialists who collaborate with the consumer's care coordinator and therapist to ensure person-centered planning.

If a person has developed a wellness recovery action plan (WRAP), cross system crisis plan or crisis management plan prior to the current crisis situation and/or has a declaration for mental health, this allows the crisis service provider to locate and follow these plans to the extent possible, including bringing in those people identified to assist with the plan. People are encouraged to develop WRAP plans not only to manage crisis situations but also for self-management of their on-going recovery.

4. Describe the person-centered planning process in your state.

The Community Supportive Housing contracts require provider agencies to enact a person-centered approach to the housing process, including the requirement to have a housing and services plan that is client-driven and person-centered.

The crisis continuum utilizes a person centered approach in all aspects of the crisis assessment. Families and other support individuals are asked to collaborate and provide observations to help define a reasonable person centered plan for crisis resolution. A crisis management plan is a documented intervention tool that itemizes and describes information and actions intended to sustain resolution of the recent crisis episode and reduce the potential for a subsequent crisis episode. When possible, the crisis management plan is a collaborative product between the crisis professional and the person in crisis and/or their designated support person(s). Similarly, all individuals and their involved supports participate in developing a safety plan that includes supports needed to remain in the community and safety checks or information on creating a safe environment.

Person-centered planning is imbedded within all mental health services contracts, from housing services to crisis services, peer support to system of care.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? ( ) Yes ( ) No

2. Are there any concretely planned initiatives in our state specific to self-direction? ( ) Yes ( ) No

   If yes, describe the currently planned initiatives. In particular, please answer the following questions:

   a) How is this initiative financed:

   b) What are the eligibility criteria?

   c) How are budgets set, and what is the scope of the budget?

   d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

   e) What, if any, research and evaluation activities are connected to the initiative?

   f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section.

Footnotes:

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ( ) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? ( ) Yes ( ) No

Does the state have any activites related to this section that you would like to highlight?

TDMHSAS Counsel serves as the Department's Chief Compliance Officer (CCO). The role of the CCO and his/her designee (the Director of Compliance) includes the following: review and facilitate compliance contracting and monitoring of programs for fidelity and integrity (with state, federal and accreditation requirements); quality assurance and improvement for all programs, contractors, and vendors; chairing the compliance review committee; and ensure that quality and compliance-related activities proceed as required for the Department at large.

Departmental program staff are responsible for review and monitoring of the programs administered within and contracted through each Division. Department fiscal staff is responsible for financial audits and coordination of the Department's monitoring process.

Providers' contracts require that other sources of funding are used prior to drawing of dollars from Block Grant funding. Contract language includes a requirement that eligibility for Medicaid and other funding is verified before utilizing Block Grant dollars for services that may be covered by insurance. In addition, providers' contracts include language pertaining to compliance with the law, compliance with the reporting of outcomes, and the specifics of program operations and payment requirements. Department staff monitors contract compliance and is responsible for audit, compliance check-ins, and communicating quality and safety standards including credentialing and selection of staff associated with the program. Staffing credentials including background checks and certification or licensing needs are also included in the contract language.

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[59] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[59] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

   Does the state have any activites related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

   The TDMHSAS has several programs and activities aimed at reducing the need for hospitalization and reducing the length of stay when hospitalization is indicated. The Department plans and promotes a comprehensive array of services and supports for individuals of all ages, living with mental illness, co-occurring disorders, and/or serious emotional disturbances. This is accomplished through the creation, expansion, and oversight of community-based programs and community support services. Initiatives include: affordable housing programs; homelessness prevention services; 24-hour crisis services; wellness and recovery services; peer recovery services; suicide prevention services; geriatric services; disaster emergency services; and a comprehensive system of care-based child, youth, and family supports services.

   The Housing and Homeless Services Office includes the Inpatient Targeted Transitional Support program. This program provides the opportunity for individuals discharged from the Regional Mental Health Institutes (RMHIs), crisis stabilization units, and state-contracted facilities to secure safe, affordable, permanent supportive housing with skill-building, educational, and life skills trainings offered to increase the functionality of each service recipient outside of the institutional setting.

   The Tennessee Move Initiative(TMI) began in FY2017 with the primary purpose of successfully transitioning identified individuals from long-term units to community based housing by providing ongoing, intensive, and individualized support to individuals, families, and community providers. TMI agencies provide recovery-focused, intensive, and customized care coordination services to identified individuals in long-term units (on average 90 + days and individuals who have had multiple admissions over a 90-120 day period) within state hospitals. The purpose of the initiative is to transition the individuals to the least restrictive and most integrated setting appropriate based on individual need. Each partner agency has developed and implemented recovery-oriented programming to ensure individual, family, and housing provider supports while connecting and coordinating with natural and formal supports within the individual's home community. The goals of TMI include: decreasing prolonged hospitalizations and repeated readmissions that impose negative implications on an individuals' quality of life, including their path to recovery; delivering recovery-focused, intensive, and customized care coordination services which support identified individuals in the least restrictive and most integrated setting appropriate to individual need; ensuring a continuity of care which leads to sustained hope, personal empowerment, respect, social connectedness, and self-responsibility relative to the individuals served; providing services centered on the individual, sensitive to the family, culturally and linguistically competent, and founded in community resources.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

   a) Physical Health — Yes / No

   b) Mental Health — Yes / No

   c) Rehabilitation services — Yes / No

   d) Employment services — Yes / No

   e) Housing services — Yes / No

   f) Educational Services — Yes / No

   g) Substance misuse prevention and SUD treatment services — Yes / No

   h) Medical and dental services — Yes / No

i)	Support services	Yes	No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	Yes	No
k)	Services for persons with co-occuring M/SUDs	Yes	No

Please describe as needed (for example, best practices, service needs, concerns, etc)

3. Describe your state's case management services

Case Management is offered as a service in the Behavioral Health Safety Net of TN. Case management is defined as care coordination for the purpose of linking safety net individuals to clinically indicated services or to benefits that would provide an alternative payer source for these services. Case management may be delivered through face-to-face encounters or may consist of telephone contacts, mail or email contacts necessary to ensure that the service recipient is served in agency office, in the community setting or through methods outlined in the Centers for Medicaid and Medicare Services (CMS) guidance on case management, including but not limited to assessment activities; completing related documentation to identify the needs of the individual; and monitoring and follow-up activities which may include making necessary adjustments in the care plan and service arrangements with providers. Case management is tied to access to services related to follow-up activities such as individual/group therapy, psychiatric medication management, pharmacy assistance and coordination and labs related to medication management; services that promote community tenure. Case management is offered to safety net individuals with a current assessment of severe and persistent mental illness and other clinical considerations.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The Department supports a number of recovery services that are intended to increase the recovery capital of people with mental health and co-occurring disorders. The Wellness & Employment Office provides Individual Placement and Support (IPS) Supported Employment services which are recovery services to help people reintegrate into their communities through competitive, steady employment. The Peer Wellness Initiative prioritizes physical health as a tool to improve mental health recovery.

The Behavioral Health Safety Net of TN is a state funded program that provides vital mental health services to uninsured Tennesseans who are eligible. The services provided through the BHSN of TN are intended to reduce hospitalizations and the recidivism rate. The services consist of: assessment, evaluation, diagnostic, therapeutic intervention, case management, peer support services, psychosocial rehabilitation services, psychiatric medication management, labs related to medication management, and pharmacy assistance and coordination.

Crisis response services are the single point of entry to a continuum of behavioral health services and supports needed by someone experiencing a behavioral health crisis. Tennessee Crisis Services incorporate a continuum of crisis services, including mobile crisis, crisis stabilization, respite and walk-in center services. The philosophy is based on determining the most appropriate intervention needed to successfully alleviate the crisis in the least restrictive environment available to meet the needs of the individual. Additionally, the TDMHSAS and Tennessee Hospital Association (THA) brought together a public/private collaboration among community partners and formed a work group to review Tennessee's current psychiatric care delivery system. These efforts include a key emphasis on providing treatment immediately at the point of entry into the health care system. The work group has developed a recommended set of Psychiatric Treatment Protocols for Emergency Department (EDs) and encourages all EDs across the state to implement these psychiatric protocols in their hospitals.

Through the First Episode Psychosis Initiative, three OnTrackTN programs provide individualized services to youth and young adults experiencing a first episode of psychosis. Youth and young adults involved in these programs experience a large reduction in number and length of hospital stays. System of Care Across Tennessee provides high-intensity wraparound services to families of children with an SED with the intent of reducing out-of-home placements, including hospitalizations.

The Department routinely monitors readmission rates for 7 and 30 day readmissions to the state and three contracted private hospitals. Each time an individual is readmitted within 7 or 30 days, a special review of the person's prior discharge plan is conducted to identify treatment failures and potential opportunities for improvement in planning the individual's plan of care.

In collaboration with the Tennessee Hospital Association, TDMHSAS has been working with community ED providers to identify ways to reduce ED waits for psychiatric inpatient care. This includes the development of treatment protocols, training of ED staff and increased utilization of telehealth for inpatient psychiatric admission evaluation. Secondary gains of these activities include, but are not limited to: increased access to emergency medication management leading to quicker stabilization and reduced need for psychiatric inpatient services and reduced reliance on the involuntary admission process to move individuals through the ED.

Tennessee is fortunate to have 24/7 access to crisis services across the state, making several diversionary alternatives available such as medically monitored crisis detoxification, crisis stabilization units, walk-in centers and respite services. The crisis system serves as the gate keeper to inpatient care.

Tennessee has also adopted the Zero Suicide Initiative aimed at improving identification of risk, safety planning, follow-up care

and routine monitoring of individuals at risk of dying by suicide. Though this initiative increases identification of individuals at risk of dying by suicide which potentially increases reliance on psychiatric inpatient care, it has also improved coordination of care among multiple providers and has improved engagement with outpatient services.

Tennessee rules and statues are designed to protect individuals from unnecessary involuntary hospitalization by requiring evaluation by two qualified mental health professionals. The first evaluation must be done by a professional unaffiliated with the inpatient service and the second is completed by the admitting physician. Individuals who do not meet commitment criteria for involuntary hospitalization are offered less restrictive alternatives to involuntary care and treatment.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	360,751	180,838
2.Children with SED	99,075	86,290

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

(A) The target population is all adults with SMI and children with SED regardless of income. (B) Tennessee uses NRI estimates of the prevalence of adults with SMI and children, ages 9-17, with SED. (C) Tennessee uses the URS tables to estimate the incidence of SMI and SED, because the URS tables contain data provided by the State Medicaid Authority, in addition to individuals served by the Department of Mental Health and Substance Abuse Services

Narratve Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	Yes No
b)	Educational services, including services provided under IDE	Yes No
c)	Juvenile justice services	Yes No
d)	Substance misuse preventiion and SUD treatment services	Yes No
e)	Health and mental health services	Yes No
f)	Establishes defined geographic area for the provision of services of such system	Yes No

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

Homeless populations within the State of Tennessee who are living with mental illness, substance abuse, or co-occurring disorders have a variety of programs available to provide permanent supportive housing and other financial services to facilitate independence in the community and increased access to behavioral health care. The programs designed to assist homeless populations include Community Supportive Housing, Projects for Assistance in the Transition for Homelessness (PATH), Inpatient Targeted Transitional Support, Community Targeted Transitional Support, Intensive Long-term Support, Emerging Adult Services, and Children and Youth Homeless Outreach Project (CYHOP). In rural areas, the PATH program provides outreach services to individuals experiencing episodes of homelessness and the Community Targeted Transitional Support program provides rental, utility, dental, and vision financial supplements to assist individuals at-risk of entering homelessness.

The Older Adult Program provides care management to individuals over 50 who would not otherwise be eligible for services. Services may include assessment, outreach, linkage, in home therapy and other supportive resources. In addition, community mental health education is provided to promote awareness regarding geriatric issues. These services are provided to improve quality of life and to develop skills to enable the older adult to continue to live independently in the community.

IPS Supported Employment is a model of employment with research indicating that it is a successful model for rural communities. Currently, there are three Individual Placement and Support (IPS) Providers in rural communities. There are also five IPS Provider specifically targeting the homeless population. The Peer Wellness programming is provided by four providers in rural areas.

The Department provides several programs targeted to rural populations: Project B.A.S.I.C. (Better Attitudes and Skills in Children), a school-based mental health early intervention and prevention program, in 35 Tennessee counties, including 23 of Tennessee's most rural counties; School Based Behavioral Health Liaisons in ten Tennessee counties, including four of Tennessee's most rural counties; System of Care Across Tennessee in four counties, including two of Tennessee's most rural counties; and the First Episode Psychosis Initiative in nine Tennessee Counties, including seven of west Tennessee's most rural counties. Other programs providing outreach to rural Tennessee counties include Violence & Bullying Prevention (a school-based bullying prevention program) and Family Support & Advocacy. Carey Counseling Center, Inc. provides targeted services to youth and young adults in rural Northwest Tennessee. Through Healthy Transitions and FEPI, Carey Counseling was able to enhance its telehealth ability and increase its capacity to serve youth and young adults in a rural area.

The crisis continuum of service is available to all Tennesseans. Crisis assessments are community based and are available statewide in both rural and urban areas. Crisis services are available to all age groups and to individuals including those that reside in the state's jails and/or are homeless.

The Behavioral Health Safety Net of TN is available to eligible uninsured Tennesseans who live in rural areas of the state and/or homeless. This is also available to individuals 19 or older.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

TDMHSAS is responsible for system planning; setting policy and quality standards; licensing personal support services agencies, mental health and substance use services and facilities; system monitoring and evaluation; and disseminating public information and advocacy for persons of all ages who live with serious mental illness (SMI), serious emotional disturbance (SED), substance use disorder (SUD), and/or co-occurring disorder (COD). Through the operation of four (4) fully accredited Regional Mental Health Institutes (RMHIs), TDMHSAS also provides inpatient psychiatric services for adults, including acute, sub-acute, and forensic. TDMHSAS is comprised of the following Department Offices and Divisions: Office of the Commissioner; Division of Administrative and Regulatory Services; Division of Mental Health Services; Division of Substance Abuse Services; Division of Hospital Services; Division of General Counsel; Division of Clinical Leadership; Division of Planning, Research, and Forensics; Office of Communications; Office of Fiscal Services; and Office of Human Resources. Through the Department Offices and Divisions, TDMHSAS provides a quality spectrum of services across the lifespan. Collaborative efforts across a variety of service systems, both public and private, including but not limited to mental health, substance use, criminal justice, veterans, and child/family organizations, create a cross-systems approach and promote the most effective outcome for care.
The Division of Mental Health Services (DMHS) is responsible for implementing programming that utilizes Mental Health Block Grant dollars. The Division of Substance Abuse Services (DSAS) is responsible for the programming that utilizes the Substance Abuse Block Grant dollars. State funding serves as the main resource for services under the purview of TDMHSAS either via Medicaid (with federal match) or TDMHSAS funding.

TennCare, the state’s Medicaid agency, operates under the purview of the Tennessee Department of Finance and Administration. TDMHSAS acts in collaboration with, and consultation for, TennCare and provides services and programs that fill the gaps for those services for SMI/SED/SUD and others diagnosed with mental health concerns not covered by TennCare.

Training for Mental Health Service Providers

The Statewide Peer Wellness Coach and Trainer provides and coordinates health and wellness, recovery and peer support training, technical assistance, and on-going support to Peer Support Center staff, Community Behavioral Health Center staff and Certified Peer Recovery Specialists, among others. This training and supports assist providers in delivering evidence-based health and wellness programming for people with co-occurring mental and substance use disorders in their communities.

The department assures that all crisis responders are adequately trained in all skills required for successful crisis intervention that also increases awareness and utilization of the most clinically appropriate and least restrictive services available. Crisis responders are required to successfully complete a self-study, web-based crisis training and complete a booster training every three years. Additionally, a six hour specialized training is provided to qualified mental health professionals that, in part, qualifies them as Mandatory Pre-screening Agents (MPA), certified to write the first “Certificate of Need” after conducting the first assessment for involuntary psychiatric hospitalization. The mandatory prescreening agents training incorporate two hour advanced training on suicide assessment. “Suicide Prevention in the Emergency Department” is a free online interactive training developed by the TDMHSAS, Mental Health America of Middle Tennessee, and the Tennessee Suicide Prevention Network to increase education for hospital emergency department staff about mental health and suicide, the screening, assessment, and referral process of patients at risk for suicide, environmental risk factors for suicide in the hospital setting, means reduction, and referral materials to provide to patients upon discharge.

Additionally, the Office of Crisis and Suicide prevention has three staff certified to train using the Evidenced based Question Persuade, Refer (QPR) a community gatekeeper suicide prevention curriculum. Staff is available to provide this training to mental health and community groups.

Be The One is a suicide prevention gatekeeper curriculum developed by the Office of Crisis and Suicide Prevention. This curriculum was specifically designed to address the major issues related to suicide in working aged adults and has been provided to central office staff at TDMHSAS as well as the mental health institutes in the state.

Tennessee has expanded OnTrackTN to two additional sites and coordinated new staff training and ongoing consultation with OnTrackUSA. The state has begun to develop a statewide First Episode Psychosis Learning Collaborative consisting of the three current OnTrackTN teams as well as other community partners and providers in order to increase awareness and early detection and increase statewide capacity to provide FEP services. As a part of the FEP Learning Collaborative, the state is planning its second statewide First Episode Psychosis Conference to be held in September 2017.

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? Yes No

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ( ) Yes ( ) No
2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? ( ) Yes ( ) No
3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? ( ) Yes ( ) No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ( ) Yes ( ) No
5. Does the state have any activities related to this section that you would like to highlight.

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

[63] http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? ( ) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ( ) Yes ( ) No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? ( ) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? ( ) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ○ Yes ○ No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? ○ Yes ○ No

3. Does the state purchase any of the following medication with block grant funds? ○ Yes ○ No

   a) ☐ Methadone

   b) ☐ Buprenophine, Buprenorphine/naloxone

   c) ☐ Disulfiram

   d) ☐ Acamprosate

   e) ☐ Naltexone (oral, IM)

   f) ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? ○ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section.

   **Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[65],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

[64] http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

[65] Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please respond to the following items:

1. Crisis Prevention and Early Intervention
   - a) ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) ☐ Psychiatric Advance Directives
   - c) ☐ Family Engagement
   - d) ☐ Safety Planning
   - e) ☐ Peer-Operated Warm Lines
   - f) ☐ Peer-Run Crisis Respite Programs
   - g) ☐ Suicide Prevention
2. Crisis Intervention/Stabilization
   - a) ☐ Assessment/Triage (Living Room Model)
   - b) ☐ Open Dialogue
   - c) ☐ Crisis Residential/Respite
   - d) ☐ Crisis Intervention Team/Law Enforcement
   - e) ☐ Mobile Crisis Outreach
   - f) ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems
3. Post Crisis Intervention/Support
   - a) ☐ WRAP Post-Crisis
   - b) ☐ Peer Support/Peer Bridges

c) é Follow-up Outreach and Support

d) é Family to Family Engagement

e) é Connection to care coordination and follow-up clinical care for individuals in crisis

f) é Follow-up crisis engagement with families and involved community members

g) é Recovery community coaches/peer recovery coaches

h) é Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

Footnotes:

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.
SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:
Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.
States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.
Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ( ) Yes ( ) No

   b) Required peer accreditation or certification? ( ) Yes ( ) No

   c) Block grant funding of recovery support services. ( ) Yes ( ) No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

   The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) serves as the state's mental health and substance use disorders and opioid treatment authority. TDMHSAS is responsible for system planning, setting policy and quality standards, system monitoring and evaluation, disseminating public information and advocacy for persons of all ages who live with mental illness, serious emotional disturbance, and/or substance use disorders.

   The TDMHSAS Planning and Policy Council system is large, robust, active, and fully-integrated with individuals from both the substance abuse and mental health communities with a consistently successful method of integration. It acts as an independent body and great care is taken by the Department to avoid influencing the deliberations of, and recommendations made by, the Councils. The Regional Council system serves a secondary purpose that, although not part of the legal requirement, is beneficial to the service delivery system in Tennessee: the Councils allow all participants to become acquainted with each other and with services, events, and other aspects of the service delivery system.

   Council membership includes: representatives of individuals and their families (51%); advocates for children; adults and elderly; service providers; stakeholder agencies and organizations (49%). The majority of each Council's membership is current or former service recipients and members of service recipient families with mental health and substance abuse disorders. With this membership mix, TDMHSAS ensures that planning for the service delivery system meets the needs of the citizens of the state at large.

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

   Tennessee has a rich system of recovery and recovery support services throughout the state for adults through peer support. Peer support, which is 100% recovery focused, is provided by Certified Peer Recovery Specialists in the state's 45 Peer Support Centers, in Crisis Stabilization Units, in the Regional Mental Health Institutes (state psychiatric hospitals), in peer wellness programs, a Peer Recovery Call Center, and in training and advocacy programs.

   Recovery and recovery support services for children with SED in Tennessee are being implemented through the Statewide and regional Young Adult Leadership Councils which are comprised of youth and young adults with lived experience, as well as the Family Support Specialist Advisory Council, comprised of parents of a child with an SED and child-serving agency stakeholders. Council members provide meaningful input and feedback on services and supports that impact themselves and their peers. Tennessee is currently working on creating a Transition-Age Designation of the Certified Peer Recovery Specialist. In addition, several programs within the Office of Children & Youth employ peers to provide recovery-focused services, including: On Track TN (FEPI) and Healthy Transitions, which utilize Peer Recovery Specialists, and System of Care Across Tennessee which utilizes Family Support Specialists.

   Tennessee certifies both Peer Recovery Specialists for adults and Family Support Specialists in the child-serving system.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

   The Tennessee Department of Mental Health and Substance Abuse Services believes that recovery is a personal process of learning new attitudes, values, goals, and skills that enable one to live a hopeful, meaningful life beyond a diagnosis of mental illness or substance use disorder. Recovery services help service recipients live a full or productive life with a disability and may result in the reduction or complete remission of problems or abstinence from addictive behaviors. Recovery services include: basic education about mental illness or addictive disorders, case management, drug testing, employment support, family support, pastoral

support/spiritual support, social activities, relapse prevention, housing, transportation, and consumer/peer support.

5. Does the state have any activities that it would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :

   - housing services provided. ( ) Yes ( ) No
   - home and community based services. ( ) Yes ( ) No
   - peer support services. ( ) Yes ( ) No
   - employment services. ( ) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? ( ) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[66]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[67]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593?602.

[68]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

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[71] http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

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Please respond to the following items:

1. Does the state utilize a system of care approach to support:

   a) The recovery and resilience of children and youth with SED? ( ) Yes ( ) No

   b) The recovery and resilience of children and youth with SUD? ( ) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

   a) Child welfare? ( ) Yes ( ) No

   b) Juvenile justice? ( ) Yes ( ) No

   c) Education? ( ) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

   a) Service utilization? ( ) Yes ( ) No

   b) Costs? ( ) Yes ( ) No

   c) Outcomes for children and youth services? ( ) Yes ( ) No

4. Does the state provide training in evidence-based:

   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ( ) Yes ( ) No

   b) Mental health treatment and recovery services for children/adolescents and their families? ( ) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

   a) to the adult behavioral health system? ( ) Yes ( ) No

   b) for youth in foster care? ( ) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

   Tennessee provides integrated services through partnerships that have been developed throughout the state since the adoption of System of Care in 1999. The System of Care in Tennessee is governed by the legislatively mandated Council on Children's Mental Health (CCMH), which brings together individuals from across the state to discuss systems, projects, and programs that touch the lives of children and youth with mental health concerns. CCMH provides a venue, five times annually, for child serving agencies to discuss current trends within the state as well as potential barriers to service. The council has various ad hoc committees that identify and problem-solve issues around financing, policy, community readiness, marketing, and other areas related to the promotion of System of Care across Tennessee. In addition to CCMH, there are numerous advisory boards, councils, and committees on which System of Care is represented to work toward improving the lives of young children, children, youth, young adults, and families across the state including: the Youth Transition Advisory Council, Healthy Transitions State Transition Team, and the Young Child Wellness Council. System of Care in Tennessee is beginning training on the use of high fidelity wraparound which will further integrate services by providing wraparound services to children and families by bringing together systems to work toward a single treatment plan among child-serving agencies. Several of our children and youth programs offer integrated services at the local level by working with schools, the juvenile justice system, and child welfare services.

7. Does the state have any activities related to this section that you would like to highlight?

The System of Care in Tennessee has been in existence for the last seventeen years and remains strong throughout the state. In 2016, the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) was awarded a four year, $12 million grant to continue the work of System of Care in Tennessee. The grant funds will assist Tennessee in expanding local interagency planning team to all ninety-five (95) counties throughout the state as well as provide for a comprehensive technical assistance center which will be available to assist in moving the System of Care philosophy forward in Tennessee.

The Therapeutic Intervention, Education, and Skills (TIES) program addresses the complex needs of children, from birth to age 17, who are at-risk of out-of-home placement due to parent/caretaker substance abuse. TDMHSAS partners with the Department of Children's Services and Centerstone, a community behavioral health treatment center, to provide Intensive Family Preservation Services and Seeking Safety treatment for children and families affected by substance abuse and trauma. Services are available for families who live in Bedford, Cannon, Coffee, Davidson, Marshall, Rutherford, and Warren counties. TIES services help keep families together and children safe and healthy.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? (•) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

   The Tennessee Suicide Prevention Network (TSPN) is a public private network to address suicide in the state. The Suicide Prevention Plan developed by TSPN with oversight by TDMHSAS is a comprehensive plan with a focus on universal, selective and indicated interventions. TSPN is overseen by a Governor appointed board. TSPN provides/coordinates with the state to provide gatekeeper training and postvention activities.

3. Have you incorporated any strategies supportive of Zero Suicide? (•) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (•) Yes ( ) No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? (•) Yes ( ) No

   If so, please describe the population targeted.

   TDMHSAS is continuing efforts and enhancing the activities of the most recent initiative which began in FFY 2014. TDMHSAS established a new initiative to reduce suicide in working age adults called Be The One: Suicide Prevention in the Workforce. The Be The One campaign is a component of Tennessee's Zero Suicide Initiative and specifically designed for public and private sectors. The campaign is based on the premise that staff, collectively, can build a supportive workforce which values and affirms life. Be The One includes suicide prevention training, suicide awareness, social marketing strategies and postvention activities

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ( ) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes ( ) No

   If yes, with whom?

   TDMHSAS continues to add new partners and/or enhance existing partnerships that help support the mission of the department. Examples include the Tennessee Hospital Association (THA), who partnered with the department in creating emergency department protocols for those experiencing a psychiatric emergency. Other partners include the Tennessee Emergency Communications Board (partnered with the department to train 911 operators in suicide prevention and crisis de-escalation), the Tennessee Commission on Children and Youth (who is formally partnering with the department on its new System of Care grant), as well as Tennessee Office of Criminal Justice Programs, who is partnering with the department to help support mental health training for local domestic violence and sexual assault centers. Federal, state, and local partners are engaged through the Interagency Council on Homelessness, coordinated by TDMHSAS, to develop and implement the Tennessee State Plan to End Homelessness. The Healthy Transitions State Transition Team is made up of state and local partners working to support policy to assist youth and young adults with or at risk of mental illness and co-occurring disorders. The Housing and Homeless Office is partnering with faith-based groups on housing initiatives.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

   The Interagency Council on Homelessness (the Council) was developed and oversees the implementation of the Tennessee State Plan to End Homelessness (the Plan). The Plan is made up of over 40 action steps and develops strong collaboration between federal, state, and local entities to ensure our state has the services and programs necessary to effectively end homelessness. A

primary component of the Council and the Plan is to ensure a greater coordination of care at the state level and between state agencies and the state's ten Continuum of Care (CoCs). To do this, the initial focus is on the creation of a cohesive message for agencies and individuals to advocate for preferences and set-asides in affordable housing programs for homeless individuals and families, to establish a statewide homeless data repository, and to continue to build stronger networks and collaborations between the state departments and local CoCs.

The Department actively involved in the Governor's Employment First Task Force, a result of Executive Order 28 to expand community employment opportunities for Tennesseans with disabilities. Department representatives serve on the Task Force, the Employment Roundtable made up of key state agency partners, and co-chair the Mental Health Work Group. The Employment First Mental Health was created in 2016 to address the small penetration rate of evidence-based employment services for people with mental health and co-occurring disorders, as well as, create a pilot site to use IPS Supported Employment for individuals with mental health and intellectual/developmental disabilities. The involvement in the Employment First Task Force helps identify best practices, partnerships and opportunities for shared services to increase integrated and competitive employment for Tennesseans with disabilities. The Department continues to collaborate with the Tennessee Department of Human Services/Vocational Rehabilitation to implement, expand, and sustain the IPS Supported Employment initiative. The Department and Vocational Rehabilitation are currently in the process of signing an interagency agreement to streamline services for persons participating in the Individual Placement and Support (IPS) program.

The Department continues to provide leadership in maximizing the efficiency, effectiveness, and quality of services through its rich System of Care (SOC) history. Through its currently funded SAMHSA SOC grant, the department aims to create local interagency planning teams in communities across the state to ensure coordination of care for children with serious emotional disturbances. The key goal for this program is to divert children and youth with SED from higher levels of care, including psychiatric residential treatment facilities. The Department also coordinates services by participating on the Council on Children's Mental Health, Youth Transitions Advisory Council, Young Child Wellness Council, the Healthy Transitions State Transition Team, the Department of Intellectual and Developmental Disabilities Employment Round Table, and the State Interagency Coordinating Council for the Tennessee Early Intervention System. The Department supports provider partners working with local school systems to provide school-based mental health early intervention and prevention services through Project B.A.S.I.C. (Better Attitudes and Skills in Children) and School-Based Behavioral Health Liaisons, as well as school-based mental health educational presentations through the Violence & Bullying Prevention and Erase the Stigma programs.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[72]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[72] http://beta.samhsa.gov/grants/block-grants/resources

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   The Statewide and Regional Councils participate in the development of the Mental Health and Substance Abuse Block Grant state plan by reviewing, monitoring, and evaluating adequacy of services for individuals with substance use and mental health disorders within the state. The Council reviews and makes recommendations on the Block Grant applications and the annual Implementation Report. See attached letter of support from Laura Berlind, Council Chair.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i ( ) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)? ( ) Yes ( ) No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   TDMHSAS operates a structured planning process with multiple layers of Planning and Policy Council involvement to ensure citizen participation in policy development and delivery-system planning. The Department oversees seven regional Planning and Policy Councils (Councils) from which local and regional mental health needs and information are funneled to the State Planning and Policy Council (Council) and ultimately to the Department. Needs assessment priorities and recommendations from the Council, combined with requirements associated with federal Mental Health and Substance Abuse Block Grant funding, inform the development of the Department's Three-year Plan for the service-delivery system. The Three-year Plan is then updated annually by TDMHSAS with input from all eight Councils.

   Membership includes: service recipients, representatives of recipients and their families; advocates for children, adults and the elderly; service providers; and stakeholder agencies and organizations. The majority of each Council's membership is current or former service recipients and members of service recipient families living with serious mental illness (SMI) and substance use disorders (SUDs). With this membership mix, TDMHSAS ensures that planning for the service-delivery system meets the needs of the citizens of the state at large.

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

[73]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

See attached letter of support from Laura Berlind, Council Chair.

August 28, 2017

Marie Williams, Commissioner
Tennessee Department of Mental Health and Substance Abuse Services
Andrew Jackson Building, 6th Floor
500 Deaderick Street
Nashville, TN 37243

RE: 2018-2019 Mental Health Block Grant Application

Dear Commissioner Williams:

The Tennessee Department of Mental Health and Substance Abuse Planning and Policy Council (TDMHSAS P&PC) is proud to support the Department in its work to serve people of all ages who have mental illness, serious emotional disturbance, and substance abuse disorders through an application for a 2018-2019 Mental Health Block Grant.

The members of the Statewide Council, along with its seven Regional Planning and Policy Councils, meet at least quarterly throughout the year to share information across regions and with TDMHSAS leadership and staff. Each year the Council requests and receives information and data from the regional councils about the mental health needs, substance abuse needs, and service gaps across the state. These needs are then prioritized and communicated to TDMHSAS to support the development of the Department's Three-Year Plan and block grant application. TDMHSAS also provides annual reporting on progress made on prior year's identified needs. Once a draft of the Block Grant application is prepared, Council members review, ask questions, and provide feedback to TDMHSAS.

The Councils represent the diverse geographic areas of the state and are comprised of a wide range of service providers and individuals with lived experience of mental illness and substance abuse disorders. The diverse representation helps insure TDMHSAS has a deep understanding of the needs and gaps in Tennessee.

As a partner and support system for the Department's work, we gladly support TDMHSAS in pursuing this grant.

Warm Regards,

Laura H. Berlind
Chair

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Richard Barber	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Aspell Recovery Center	331 North Highland Avenue Jackson TN, 38301 PH: 731-427-7238	rbarber@aspellrecovery.com
Laura Berlind	Family Members of Individuals in Recovery (to include family members of adults with SMI)	The Sycamore Institute	150 4th Avenue North, Suite 1870 Nashville TN, 37219 PH: 615-495-2670	lberlind@sycamoreinstitutetn.org
Renee Bouchillon	State Employees	Tennessee Department of Human Services-Social Services	1400 College Park Drive Columbia TN, 38401 PH: 931-380-2563	Renee.Bouchillon@tn.gov
Melanie Brander	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		250 Winters Court, Apt.E Clarksville TN, 37043 PH: 931-980-9709	mbrander25@yahoo.com
Libby Byler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1900 Acklen Avenue, Apt. 1706 Nashville TN, 37212 PH: 615-415-0227	libby.byler@amerigroup.com
Jan Cagle	Providers	Ridgeview Behavioral Health Services	24 West Tryone Road Knoxville TN, 37830 PH: 865-482-1076	caglejg@ridgevw.com
Cherrell Campbell-Street--Vocational Rehabilitation	State Employees	Tennessee Department of Human Services-Social Services	Vocational Rehabilitation Nashville TN, 37243 PH: 651-313-4713	Cherrel.Campbell-Street@tn.gov
Ashley Evans	Providers	Volunteers in Medicine, Chattanooga, Inc.	P.O. Box 81057 Chattanooga TN, 37414 PH: 423-855-8220	aevans@vim-chatt.com
John Fisher	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Lakeside Behavioral Health Systems	2911 Brunswick Road Memphis TN, 38133 PH: 901-312-8237	john.fisher@uhsinc.com
Paul Fuchcar	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	CADAS	207 Spears Avenue Chattanooga TN, 37405 PH: 423-667-3311	paul.fuchcar@cadas.org
Ben Harrington	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health America	P.O. Box 32731 Knoxville TN, 37930-2731 PH: 865-584-9125	ben@mhaet.com
			500 Professional	

Rikki Harris	Others (Not State employees or providers)	TN Voices for Children	Park Drive Goodlesttsville TN, 37072 PH: 615-269-7751	rharris@tnvoices.org
Marta Hernandez	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Alliance Health Care	1321 Murfreesboro Pike Suite 155 Nashville TN, 37217 PH: 615-780-5901	michelle@taadas.org
Mike Herrmann	State Employees	Tennessee Department of Education	710 James Roberston Pkwy Nashville TN, 37243 PH: 615-741-8468	Mike.Herrman@tn.gov
Debbie Hillin	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Buffalo Valley, Inc	5465 Village Way Nashville TN, 37211 PH: 615-975-0196	debbiehillin@buffalovalley.org
Brittney Jackson	Parents of children with SED	Tennessee Voices for Children	500 Professional Park Drive Goodlettsville TN, 37072 PH: 615-856-0531	bjackson@tnvoices.org
Emma Johnson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Park Center	948 Woodland Street Nashville TN, 37206 PH: 615-242-3576	emma.johnson@parkcenternashville.org
Jennifer Jones	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Tennessee Mental Health Consumers' Association	3931 Gallatin Road Nashville TN, 37216 PH: 615-250-1176	jjones@tmhca-tn.org
Wayne King	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1503 Dexter Laxton Road Oneida TN, 37841 PH: 423-215-2607	trulight@live.com
Deanna King	Providers	Youth Villages	6236 Airpark Drive Chattanooga TN, 37421 PH: 423-954-8844	deanna.doran@youthvillages.org
Linda Lewis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		P.O. Box 474 McKenzie TN, 38201 PH: 731-418-9307	llewis38201@yahoo.com
Emma Long	Family Members of Individuals in Recovery (to include family members of adults with SMI)		94 Labelle Street Jackson TN, 38301 PH: 731-326-2041	emmaelon@aol.com
Claudia Mays	Providers	CM Counseling & Consulting Services	P.O. Box 70344 Nashville TN, 37218 PH: 615-256-8641	cmayscounseling@att.net
Debbie Miller	State Employees	Tennessee Department of Children's Services	436 6th Avenue North Nashville TN, 37243 PH: 615-741-4206	Debbie.Miller@tn.gov
Ginger Naseri	Providers	Nolachuckey Holston Area Mental Health Center	401 Holston Drive Greeneville TN, 37743 PH: 423-639-1104	vnaseri@frontierhealth.org

Robin Nobling	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI	1101 Kermit Drive, Suite 608 Nashville TN, 37217 PH: 615-891-4724	rnobling@namidavidson.org
Linda O"Neal	State Employees	Tennessee Commission on Children and Youth	502 Deaderick Street Nashville TN, 37243 PH: 615-741-2633	Linda.Oneal@tn.gov
Mary Nelle Osborne	Providers	Peninsula Lighthouse	1451 Dowell Springs Blvd. Knoxville TN, 37909 PH: 865-374-7140	mosborn1@CovHlth.com
Senator Doug Overby	Others (Not State employees or providers)		4 Legislative Plaza Nashville TN, 37243 PH: 615-741-0981	sen.doug.overbey@capitol.tn.gov
Kim Parker	Providers	Pathways	238 Summar Drive Jackson TN, 38301 PH: 731-541-8988	Kim.Parker@wth.org
Tim Perry	Providers	Nolachuckey Holston Area Mental Health Center	2106 Moccasin Street South Kingsprot TN, 37660 PH: 423-245-4263	dbowers@frontierhealth.org
Elliot Pinsley	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Centerstone Mental Health Center	1921 Ransom Pl Nashville TN, 37217 PH: 615-460-1254	elliot.pinsley@centerstone.org
Perry Pratt	Providers	Youth Town	3641 Youth Town Road Pinson TN, 38301 PH: 731-513-1130	PPratt@youtown.net
Representative Bob Ramsey	Others (Not State employees or providers)		301 6th Avenue North Nashville TN, 37243 PH: 615-741-3560	
Albert Richardson	Providers	C.A.A.P.	4023 Knight Arnold Road, Suite 300 Memphis TN, 38118 PH: 901-360-0442	ARichardson@caapincorportated.com
Susan Seabourn	Providers	Centerstone Mental Health Center	Centerstone Mental Health Center Nashville TN, 37204 PH: 615-460-4451	susan.langneus@centerstone.org
Pat Starnes	Family Members of Individuals in Recovery (to include family members of adults with SMI)		4325 Shady Dale Road Nashville TN, 37218 PH: 615-330-1832	trucare10@yahoo.com
Jack Stewart	Family Members of Individuals in Recovery (to include family members of adults with SMI)		14374 Asheville Highway Greeneville TN, 37743 PH: 423-787-1663	bluespringsdc@yahoo.com
Wendy Sullivan	Parents of children with SED	Tennessee Voices for Children	500 Professional Park Drive Goodlettsville TN, 37072 PH: 615-269-7751	wsullivan@tnvoices.org
Betty Teasley-Sulmers	State Employees	Tennessee Housing Development Agency	404 James Roberston Pkwy Nashville TN, 37243	bteasleysulmers@thda.org

			PH: 615-815-2125	
Libby Thurman	Others (Not State employees or providers)	Tennessee Primary Care Association	3109 Wingate Avenue Nashville TN, 37211 PH: 615-497-4942	libby.thurman@tnpca.org
Marthagem Whitlock	State Employees	Tennessee Department of Mental Health and Substance Abuse Services	500 Deaderick Street, 5th Floor Nashville TN, 37243 PH: 615-532-6744	marthagem.whitlock@tn.gov
Commissioner Marie Williams	State Employees	Tennessee Department of Mental Health and Substance Services	500 Deaderick Street Nashville TN, 37243 PH: 615-532-6500	marie.williams@tn.gov
June Winston	Providers	Lowenstein House	821 S. Barksdale Street Memphis TN, 38114 PH: 901-274-5486	June.Winston@lowensteinhouse.com
Dianne Young	Family Members of Individuals in Recovery (to include family members of adults with SMI)	The Healing Center	3885 Tchulahoma Road Memphis TN, 38114 PH: 901-370-4673	YHealer@aol.com

Footnotes:

The 2017-2018 TDMHSAS Planning and Policy Council Ex Officio Member list is attached. This list includes specific agency representation. The Department of Corrections member position is vacant at this time. This position will be filled as soon as a new employee is hired.

TDMHSAS Planning and Policy Council
2017-2018
Ex Officio Members

	Phone:	615.532.6500
Commissioner Marie Williams, LCSW	Fax:	615.532.6514
TDMHSAS	e-mail:	marie.williams@tn.gov
Andrew Jackson Bldg., 6th Floor		
500 Deaderick Street		
Nashville, TN 37243		
Governor Bill Haslam	Phone:	615.741.2001
State of Tennessee	Fax:	615.532.1353
State Capitol, 1st Floor		
Nashville, TN 37243		
Renee Bouchillon	Phone:	931.380.4636
Department of Human Services	Fax:	931.380.3395
District Office, Suite B	e-mail:	renee.bouchillon@tn.gov
1400 College Park Drive		
Columbia, TN 38401		
Cherrell Campbell-Street, Assistant	Phone:	615.313.4713
Commissioner	Fax:	615.741.6508
DHS Rehabilitation Services	e-mail:	cherrell.campbell-street@tn.gov
Citizens Plaza, 15th Floor		
400 Deaderick Street		
Nashville, TN 37243		
Dr. Bruce Davis	Phone:	615.532.1610
Dept. of Intellectual Developmental Disabilities	e-mail	bruce.davis@tn.gov
Citizens Plaza, 10th Floor		
400 Deaderick Street		
Nashville, TN 37243		
Mike Herrmann	Phone:	615.741.8468
Department of Education	e-mail:	mike.herrman@tn.gov
Andrew Johnson Tower, 7th Floor		
710 James Robertson Pkwy.		
Nashville, TN 37243		
Debbie Miller	Phone:	615.741.9206
Department of Children's Services	Fax:	615.253.0069
UBS Tower, 10th Floor	e-mail:	debbie.miller@tn.gov
315 Deaderick Street		
Nashville, TN 37243		
Michael Myszka	Phone:	615.741.8142
Bureau of TennCare, 3rd Floor	Fax:	625.741.0064
310 Great Circle Road	e-mail:	michael.myskka.@tn.gov
Nashville, TN 37243		

Jeff Ockerman, Director of Planning Department of Health Andrew Johnson Tower, 2nd Floor 710 James Robertson Pkwy. Nashville, TN 37243	Phone: e-mail:	615.532.3188 jeff.ockerman@tn.gov
Linda O'Neal, Executive Director TN Commission on Children & Youth Andrew Johnson Tower, 9th Floor 502 Deaderick Street Nashville, TN 37243	Phone: Fax: e-mail:	615.741.2633 615.741.5956 linda.oneal@tn.gov
Betty Teasley Sulmers Tennesee Housing Development Agency 404 James Robertson Pkwy. Nashville, TN 37243	Phone: Fax: e-mail:	615.815.2125 615.253.6406 bteasleysulmers@thda.org
Sarah Wellman, Psy.D Department of Correction Rachel Jackson Bldg., 5th Floor 320 6th Ave. North Nashville, TN 37243	Phone: e-mail	615.253.8163 sarah.wellman@tn.gov
Marthagem Whitlock, Assistant Commissioner TDMHSAS Div. of Planning, Research & Forensics Andrew Jackson Bldg., 5th Floor 500 Deaderick Street Nashville, TN 37243	Phone: Fax: e-mail	615.532.6744 615.532.6514 marthagem.whitlock@tn.gov
Wanda Willis TN Council on Developmental Disabilities Parkway Towers, Suite 130 404 James Robertson Pkwy. Nashville, TN 37243	Phone: e-mail:	615.253.5369 wanda.willis@tn.gov

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	47	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	10	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	9	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	25	53.19%
State Employees	8	
Providers	12	
Federally Recognized Tribe Representatives	0	
Vacancies	2	
Total State Employees & Providers	22	46.81%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (•) Yes ( ) No

b) Posting of the plan on the web for public comment? (•) Yes ( ) No

c) Other (e.g. public service announcements, print media) (•) Yes ( ) No

If yes, provide URL:

The draft plan was posted on the Tennessee Department of Mental Health and Substance Abuse Services website in the Planning and Policy Council area and on the home page. That area is located at the following link: http://tn.gov/behavioral-health/article/mental-health-block-grant.

Comments, changes, and questions were invited via direct email or phone call to the Director of Planning (author of the plan). The draft Plan was also sent to statewide and regional Council members to review and comment.

Footnotes: